TRANSFERENCE: AN EMPIRICAL INVESTIGATION ACROSS A RANGE OF COGNITIVE-BEHAVIOURAL AND PSYCHODYNAMIC THERAPIES

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CONTENTS

ABSTRACT

Transference and the focus of therapists' interventions were empirically investigated across a range of cognitive-behavioural and psychodynamic therapies. A conceptual analysis of transference definitions identified eight key components which were then utilised to construct an instrument for coding patient and therapist statements. The instrument showed good reliability in a pilot study which coded 40 verbatim transcriptions of therapy sessions drawn equally from each of two cognitive-behavioural therapies (cognitive-behaviour and cognitive) and two psychodynamic therapies (conversational and focal psychodynamic). The main study coded 88 therapy sessions drawn from six psychological therapies; the four therapies investigated in the pilot study and a further cognitive-behavioural therapy (behaviour) and a further psychodynamic therapy (psychoanalytic). It also investigated more broadly the focus of therapists' in-session interventions, and patients' negative commentary about therapists and therapy and therapists' response to it.

The results showed that transference references were not unique to psychodynamic therapies but occurred in cognitive-behavioural therapies too. However the frequency of these references were significantly lower in cognitive-behavioural therapies, and the structure and process of psychodynamic therapies were considered to encourage, as they are designed to, the expression and exploration of transference. Therapists in psychodynamic therapies made more references to transference components and more statements linking these components together. They also responded more fully to patients' references about the therapist and explored the patient-therapist relationship more. By contrast, patients' explicit references to current feelings and thoughts about the therapist were little addressed by cognitive-behavioural therapists. Furthermore, negative feelings about the therapy and the therapist were responded to restrictively whereas in psychodynamic therapies their exploration was facilitated. It is therefore of note that in cognitive-behavioural therapies patient implicit references to the therapist were much higher than their respective explicit references, that there were higher levels of negative feelings about the therapist and therapy, and that late sessions of therapy saw a rise over early sessions in implicit references to both. It is suggested that transference references do not tend to lessen if they go unrecognised or unacknowledged. Thus within the cognitive-behavioural therapies the level of patients' transference references generally stayed the same across early and late sessions. Moreover, patient explicit and implicit references to conflictual feelings toward the therapist actually increased. It is also suggested that transference references do not tend go away if they are recognised and explored, rather there is a process of increasing awareness of them. Thus within psychodynamic psychotherapies there was some evidence of patient explicit transference references increasing and their implicit references lessening. The implications of the research's findings are discussed with respect to mutative processes in cognitive-behavioural and psychodynamic psychotherapies. It is argued that evolution in both the psychoanalytic view of transference and in cognitive-behavioural therapies has led to increasing common ground, that of an internal mental structure pervasively mediating experience. It is also argued that the concept of transference can inform cognitive-behavioural therapies, and facilitate the maintenance of a therapeutic alliance, and an understanding of ruptures in it, and thereby potentially impact positively on outcome.

(84,929 words plus tables)

CHAPTER 1

INTRODUCTION

1.1 Introduction

The concept of transference, wherein unconscious aspects of a patient's early relationship to parental figures is lived out with a therapist rather than remembered, was introduced into psychology by Freud (1895) a little over a hundred years ago. Since then it has become the cornerstone of psychodynamic therapy. Despite this lengthy history and prominence, the empirical literature on transference is slight. This situation has arisen because the majority of those for whom transference has been a clinical imperative have considered empirical research antithetical to their practice. A psychoanalyst reviewing one such attempt wrote, "The book is seriously flawed by ..... an attempt to introduce a quantifiable schema for thinking about and measuring certain aspects of a transference-countertransference interaction" (Carpy, 1990). There is a minority of psychodynamic therapists however, growing in the climate created by the NHS reforms and the demand for evidence based practice, who support empiricism. Wallerstein (1990) argued that the (natural) science commitment of earlier, Freudian psychoanalysis, had been progressively eroded. He went on to argue a need for empiricism to advance the divergent, and primarily metaphoric, theories of psychoanalysis. For he and for Goldfried and Safran (1986) empirical study of psychodynamic theories needs to be directed at the common ground of low-level clinical theory. At this level, they argue, clinical constructs such as transference can be put to empirical study that will guide clinical work.

1.1.1 The Patient-Therapist Relationship

Little researched 'in its own backyard', it is perhaps not suprising that there is a dearth of research on transference in psychological therapies which consider the patient-therapist relationship as less pivotal. With respect to behaviour therapy, for example, Morris and Magrath (1983) in a review of the patient-therapist relationship concluded that the relationship, unless there was treatment

noncompliance, did not significantly influence outcome. This is in marked contrast to psychodynamic therapy in which transference is considered inexorably a part of the patient-therapist relationship. Here the relationship is the primary vehicle of change, on which the therapist brings to bear technical operations to effect this change. In considering the occurrence of transference across a range of psychological therapies there is a need to consider the context in which it would occur, the patient-therapist relationship.

O'Leary and Wilson (1987), in line with Morris and Magrath (1983), viewed the patient-therapist relationship in behaviour therapy as a collaborative setting for the implementation of behavioural techniques. Behaviour therapy has moved from seeing noncompliance as the client's lack of motivation to a failure of the therapist to take an adequate initial conspectus of the patient's problems (Wolpe, personal communication). It does not consider noncompliance a source of learning and change. Cognitive therapy may explore noncompliance to uncover faulty assumptions. As such it is closer to Freud's (1912) view that 'Resistance accompanies the treatment step by step..... represents a compromise between the forces striving towards recovery and the opposing ones..' (p. 103). Psychodynamic therapies consider the patient-therapist relationship 'the single most important precondition to (the) success' (Waterhouse and Strupp, 1984, p.77). Resistance, unlike in behaviour therapy, is an expected and necessary part of the change process. Freud considered transference was 'used as a weapon by the resistance, but in the hands of the physician it becomes the most powerful therapeutic instrument...' (1923, p.247).

Stiles, Shapiro and Elliot (1986) considered one explanation of 'outcome equivalence, content non-equivalence' of differing psychotherapies was a common core of mutative features. One frequently cited commonality is the patient-therapist relationship, the therapeutic alliance (Goldfried and Padawer, 1982), a term first used by Freud (1895) who saw it as one aspect of positive transference. Kerr, Goldfried, Hayes, Castonguay and Goldsamt (1992) found, in exploratory therapy, a positive correlation between exploration of the patient-therapist relationship and treatment outcome, but that in prescriptive therapy there was not. Cognitive-behaviour therapists need to explore the patient-therapist relationship to some degree to maintain a working alliance and Kerr, Goldfried, Hayes and Goldsamt (1989) found no significant difference between them and psychodynamic therapists in their tendency to emphasise intrapersonal or interpersonal links. So what is going wrong for cognitive-behaviour therapists when they address a specific interpersonal case, their working relationship with a patient ?

Psychodynamic therapy facilitates the patient re-experiencing interpersonal styles in relation to the therapist that are derived from conflictual childhood experiences. Strupp and Binder (1984) used

the term 'enactment' to describe this. Whether such re-experiencing occurs in other therapeutic approaches but is not recognised or worked with has been little considered. Arkowitz and Hannah (1989), however, proposed that a common mutative factor in psychotherapy was providing patients with experiences related to their problems along with disconfirmation of the expectancies that previously mediated them. Whereas psychodynamic therapy facilitates 'problem-congruent' experiences within the patient-therapist relationship, for example, an aggressive patient acting aggressively toward the therapist (cf. Arkowitz and Messer (1984) who argue that the provision of a new experience related to the problem, along with affective arousal, leads to disconfirmation of expectancies that mediated the problem and thereby change) behaviour and cognitive therapies most commonly encourage problem-incongruent behaviour, for example, being asked to put oneself in feared situations.

1.1.2 Psychotherapy Integration

Although historically behaviour, cognitive and psychodynamic therapies have evolved along separate routes there have been points of overlap. The work of Bandura (1969) was an early indicator of a trend in the expansion of behaviour therapy from a non-mediational basis to one involving cognitions, and attempts at integrating psychodynamic and behaviour therapies have an even longer history (French, 1933; Dollard and Miller, 1950).

The integration of different psychotherapies however has been limited, with Brewin and Power (1997) noting that "authors have generally preferred to explore the merits of their own brand of psychotherapy rather than to seek common cause with others." (p.1). Wachtel (1982) argued, for example, that few behaviour therapists utilised psychoanalytic concepts, this despite Crisp (1966) and Rhoads and Feathers (1972) finding support for the presence of transference in behaviour therapy. Freud (1912) had, many years earlier, argued that "... transference emerges as the most powerful resistance to (the) treatment" (p. 103). But behaviour therapy has not embraced such a view of treatment resistance nor that the treatment noncompliance it commonly encounters is a source of learning and change. Some cognitive therapists do now explore the patient-therapist relationship and may utilise noncompliance to uncover faulty assumptions (e.g. Safran and Segal, 1996). However, as Power (1989) noted, cognitive therapy offers no substantive theoretical framework from which to tackle core assumptions. Transference has no more been truly incorporated into cognitive therapy than behaviour therapy even though the views of cognitive theorists such as Guidano and Liotti (1983) exemplify that a cognitive model of transference is clearly feasible (cf. Mallinger, 1974). There is much similarity between Guidano and Liotti's work

and that of psychoanalysts such as Bowlby (1988). The former view schemata as preconscious and derived from early childhood experiences; the latter writes of an internal world created in early childhood from experiences with external reality. The concept of schemata may be equated with that of the internal world and like the internal world, the well spring of transference, schemata may be inexorably linked with transference. This raises for consideration the occurrence of transference in cognitive therapy and how therapists may work with it.

As cognitive therapy has increased in popularity questions have been raised by some as to its efficacy. Hughes (1997) points to the relatively disappointing results of cognitive therapy in the National Institute of Mental Health multicentre trial (cf. Jacobson and Hollon, 1996). He also argues that Beck himself (Hollon and Beck, 1994) has suggested caution and noted that there is no proof that cognitive therapy has long term benefits in preventing relapse in depressed patients. In the United States of America where cognitive therapy initially evolved clinical psychologists and psychotherapists mostly work in private practice and it may be argued are more likely to see reasonably well motivated clients from higher socio-economic brackets. Hughes compares the middle class professionals treated by Beck and cited by him (1979) with the depressed patients he sees, typically a single parent, with a history of abusive relations and marked social problems. He goes on to argue that in his experience some clients find cognitive therapy too theoretical an exercise and others that it is an attempt to make them think "correctly".

Cognitive psychologists such as Teasdale and Barnard (1993) and Power (1997) have argued that Beck's (Beck, Rush, Shaw & Emery, 1979) schema model lacks the flexibility to satisfactorily explain the thinking of depressed people. Brewin (1997) argues that its emphasis on depressed persons illogicality is incorrect and refers to earlier empirical work by himself (Brewin, Smith, Power and Furnham, 1992) which showed that people with depression can "discriminate their current views of themselves, their perception of how they are generally and their perception of how they have ever been." (p.117). Brewin posits that:

> the existence of complex representations of self and others suggests that cognitive distortions cannot simply be explained in terms of a drive for cognitive consistency with a single negative self-schema. From a psychological defence perspective, negative thoughts and logical errors may be maintained because they enable the individual to avoid confronting other specific unwanted thoughts, emotions and memories. Resistance thus arises because there are real feared consequences of thinking or acting in a different way. Individuals will vary in the extent to which they are aware of these feared consequences. Such ideas are of course commonplace to psychoanalytically trained therapists..... (p.117).

He goes on to express his suprise that cognitive therapy for anxiety and depression has not addressed explicitly the issue of psychological defences and their role in the treatment process and concludes that "it seems likely that the next decade will lead to a much greater appreciation of the mechanisms underlying psychological defences and to their incorporation within mainstream cognitive therapy." (p.119). On a different note, Teasdale (1997) points to how within cognitive therapy 'rational argument' is frequently ineffectual in attempting to change emotional response. He questions the 'classic' cognitive therapy suggestion that rather than there being an essential difference between intellectual belief and emotional belief that they are simply *quantitative* variations in degree of belief. He cites by way of example Beck et al, (1979) :

> Patients often confuse the terms "thinking" and "feeling". This semantic problem is most obvious when the patient mistakenly uses the word 'feel' for 'believe', for example, 'I feel you're wrong'. The therapist can tell the patient that a person cannot believe anything 'emotionally'. Emotions include feelings, sensations; thoughts and beliefs lead to emotions. When the patient says he believes or does not believe something emotionally, he is talking about *degree of belief* (p.302, original italics).

and posits that 'many clinicians have found this analysis unconvincing, regarding 'emotional' belief as qualitatively distinct from 'intellectual' belief, and functionally more important' (p.142). Linehan (1993) stated that the cognitive-behavioural therapies she practised '..invalidated my patients. I was telling them that either their behaviour was wrong or their thinking was irrational or problematic in some way.' (p.77). In working with parasuicidal patients she became 'convinced that the problems of these patients did not result primarily from cognitive distortions of themselves and their environment...' (p.29) and also found that she could not get them to stay with her treatment plans. Such issues are likely to become more prevalent as NHS reforms bite and psychologists and psychotherapists increasingly focus their clinical time on people with severe and enduring mental health problems, many groups of which, for example borderline and parasuicidal patients, are renowned for being difficult to engage and retain in therapy (Gunderson, 1984); the former's impulsivity and unstable and destructive behaviour toward themselves and others has meant widespread reluctance to treat them. Indeed many psychiatrists consider borderline personality disorder to be untreatable and not a mental illness at all. Whilst the cognitive and behaviour therapy literature on patient compliance is increasing (Meichenbaum and Turk, 1987), very little is written by cognitive and behaviour therapists on therapist behaviour that facilitates or interferes with this compliance and of how patients' defence mechanisms expressed in the transferential relationship impede and inform the therapeutic process.

The New Cognitive-Behaviour Therapies and Borderline Personality Disorder

In recent years new cognitive-behaviour therapies such as Schema Focused Cognitive Therapy (Young, 1994) and Dialectical Behaviour Therapy (Linehan, 1993) have evolved. These have incorporated psychoanalytic concepts and techniques because of difficulties in effectively treating some patient groups, such as those with borderline personality disorder. In fact, interest in the treatment of people with disorders of personality has only been recent in cognitive therapy (cf.Layden, Newman, Freeman and Byers-Morse, 1993).

Borderline Personality Disorder

Borderline has been a common psychoanalytic ascription for more than 50 years, being first used by Stern (1938) to describe a group of patients who were neither neurotic nor psychotic. Work by psychoanalysts such as Kernberg (1975) and Kohut (1977) on borderline personality organisation have drawn a large audience not just within psychoanalysis but in mainstream mental health too. The appearance of borderline personality disorder as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980) reflected and heralded increasing interest in a group of patients who are major users of resources and who are frequently referred to mental health services whose ability to treat them successfully is small. Many who initially appear suitable for out patient psychotherapy tend to do poorly in treatment which is then terminated and/or hospitalisation instigated. Once in hospital they tend to deteriorate behaviourally and they engender intense anger and helplessness in clinicians. The Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 1994) identifies the following diagnostic criteria:

- unstable and intense interpersonal relationships alternating between idealisation and devaluation
- impulsivity
- affective instability
- inappropriate intense anger
- chronic feelings of emptiness
- suicidal and self-mutilating behaviours
- identity disturbance
- frantic efforts to avoid abandonment.

Eleven per cent of all psychiatric out-patients and 19% of in-patients meet DSM IV criteria for a diagnosis of borderline personality disorder, 75% have a history of at least one self injurious act

(Cowdry, Pickar and Davis, 1985) and in the region of 9% successfully commit suicide (Stone, 1993). Millon (1993) suggests that the prevalence of borderline personality disorder has increased over the last 25 years and explains this in terms of the recent rapidity of social change, the loosened ties of family and increased social anomie. Ryle (1997) argues that:

> the combination of the unprecedented violence of this century with its heightened competitive individualism has placed far more demands on the internal structure of the self. Whereas, in the past, damaged people might have been contained by the institutions of family and workplace, the modern individual has fewer such supports and faces more demands, being expected to continually demonstrate his or her worth by achievement, ... while being offered decreasing security. Borderline patients are one of the mental health treatment challenges of the millennium (p.9).

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy applies a broad range of cognitive-behaviour therapy procedures including problem solving, exposure techniques, skills training and cognitive modification. Linehan (1993) identifies a number of aspects that set it apart from usual cognitive behaviour therapy including not viewing behavioural and emotional problems as necessarily resulting from dysfunctional cognitive processes. She argues that cognitive-behaviour therapists have always noted the importance of the therapeutic alliance but, excepting Safran and Segal (1990), have written little about how to achieve it, and have attended little to behaviours that interfere with therapy, with the exception of treatment compliance (cf. Shelton and Levy, 1981). In contrast, Dialectical Behavioural Therapy focuses on therapy interfering behaviours and the therapeutic relationship, seeing this as essential to treatment. Linehan sees this emphasis as 'more similar to the psychodynamic emphasis on "transference" behaviours than it is to any aspect of standard cognitive-behavioural therapies.' (p.15). She notes that Kohlenberg and Tsai (1991) have recently developed an integrated behaviour therapy in which the vehicle of change is the relationship between the therapist and patient and acknowledges their influence on her own work.

Schema Focused Cognitive Therapy

Young (1994) argued that people with personality disorders or other severe mental health problems violate many of the basic assumptions of cognitive therapy, namely :

i) *patients have access to thoughts and feelings with brief training.* However, many patients are not in touch with their feelings and automatic thoughts and appear to actively resist attempts to change this.

ii) *patients have identifiable problems on which one can focus.* But many patients' problems are hard to define or find a focus for.

iii) *patients are motivated to do homework and learn self help strategies.* Many patients however show strong resistance to undertaking homework and learning strategies to help themselves.

iv) *patients can quickly engage in a therapeutic alliance.* Many patients are difficult to engage in a therapeutic alliance. Some patients are so driven toward dependency or hostility that they are unable to collaborate with the therapist.

v) *difficulties in the therapeutic relationship are merely problems to overcome.* In fact most personality disordered patients have significant interpersonal problems and these are enacted with the therapist. Their difficulties are derived from relationships in early life and show themselves in present day relationships. With such patients, exploration, insight and readjustment around the patient-therapist relationship needs to become the focus of treatment but cognitive therapy has little to say about how to work in this way.

vi) *cognitions and behaviour can be changed through experimental analysis, logical discourse, experimentation, gradual steps and practice.* The cognitions and problematic behaviours of many patients are resistant to modification purely through short term cognitive-behavioural techniques. They may intellectually understand the therapy but they remain unchanged. Pervasive and inflexible ways of relating to others are pathognomonic of personality disordered patients (cf. Diagnostic and Statistical Manual of Mental Disorders IV, American Psychiatric Association, 1994).

Young's attempts to overcome the impediments he believes patients with personality disorders present to effective psychological treatment, in particular their affective and cognitive rigidity, avoidance of painful thoughts and feelings, and interpersonal difficulties, led him to develop Schema Focused Cognitive Therapy. This, he argues 'expands on conventional cognitive behaviour therapy by placing more emphasis on the therapeutic relationship, affective experience, and the discussion of early life experience' (1994, p.vii). Young notes that Beck et al (1979) refer to the importance of working with schemas in treatment but have offered few guidelines, focusing instead on less deep cognitive phenomena: automatic thoughts, cognitive distortions and underlying assumptions. He proposes a primary emphasis on the deepest level of cognition, the 'Early Maladaptive Schema', stable and enduring themes that seem to arise from dysfunctional

childhood experiences with parents and peers. Millon (1981) notes that such early negative experiences:

> do more than passively contribute their share to the present... they guide, shape or distort the character of current events. Not only are they ever present, then, but they operate insidiously to transform new stimulus experiences in line with the past (p.101).

The similarity between Young's work on early maladaptive schema and the work of Guidano and Liotti (1983) which pre-dates it is clear. Clear too is the overlap with the work of the psychoanalyst Bowlby on 'templates' (1988) and with the concept of transference. Cognitive schema-focused therapy is a cognitive therapy and its practice differs from psychodynamic therapy in a number of ways. Cognitive schema-focused therapists are more active and directive than their psychodynamic counterparts, they utilise traditional cognitive and behavioural techniques, set self help homework assignments, and consider the analysis of evidence a critical aspect of schema change. But there is common ground. Like psychodynamic therapy, cognitive schema-focused therapy emphasises the need for affective arousal in therapy for change to occur. And of the four techniques he suggests for activating schemas: encouraging the patient to discuss distressing current events, distressing childhood events and images which come to mind spontaneously, and the discussion and exploration of the patient-therapist relationship, Young identifies the latter as the exploration of transference, a psychodynamic technique. But in fact the other three techniques are psychodynamic too if one equates the spontaneous reporting of images that Young recommends with the psychodynamic technique of encouraging the reporting and then subsequent exploration of dreams. Freud (1900), paraphrasing one of his favourite German wits, Lichtenberg, who commended the study of dreams as the avenue to otherwise inaccessible self knowledge considered such dream interpretation the 'royal road to a knowledge of the unconscious activities of the mind.' (p.769).

But despite developments in cognitive therapies most cognitive-behaviour therapists have not familiarised themselves with psychoanalytic literature. Nor have they, as indicated above, truly recognised the potential of transference and countertransference to throw light on many clinical problems including treatment noncompliance, non attendance and premature termination of therapy.

Cognitive Analytic Therapy

The development of Cognitive Analytic Therapy (CAT) by Ryle (1982, 1990, 1995) predates Young's Schema Focused Cognitive Therapy and Linehan's Dialectical Behaviour Therapy. As its name suggests CAT is, states Ryle (1997), "an integration of cognitive and psychoanalytic ideas in which a main influence was my use of repertory grid techniques to measure and describe change in the course of psychodynamic psychotherapy" (p.12). In undertaking this research patients were asked to identify the problems that led to their seeking therapy (their target problems or TPs) and to describe the ways in which they were caused and maintained (target problem procedures). This process led to the therapist and the patient devising a joint descriptive reformulation, in effect a description of the patient's difficulties and the processes underlying them. Thus it is description rather than interpretation that is characteristic of CAT. In fact it may be argued that while Ryle states that CAT is an integration of cognitive and psychoanalytic ideas, that the ambience of the patient-therapist encounter and the theorising directing it is, along with Schema Focused Cognitive Therapy and Dialectical Behaviour Therapy, far more squarely a cognitive one. Ryle (1998) argues that Schema Focused Cognitive Therapy and Dialectical Behaviour Therapy inadequately address the patient's early life experience and the link between this and current experience through underlying processes and structures. Transference is seen as an example of the general way in which role reciprocation is elicited; reciprocal role procedures are concerned with maintaining relationships through the predicting or eliciting of a response from the other and are seen to have their origins in the childhood relationship with caretakers.

The integration of different psychotherapeutic approaches has become a clinical reality as therapists from different orientations confront the limitations of their specific paradigms (cf. Goldfried, 1993). This confrontation has occurred as part of a natural evolution of therapies but has also been bought about by NHS Reforms which have led to psychological therapists working in out patient settings with people with severe mental health problems with their efficiency and effectiveness in so doing being under increasing contractual scrutiny. As cognitive therapists move to consider analytic concepts and techniques such as exploring the patient-therapist relationship and extending treatment lengths (cf. Safran and McMain, 1992) so too have psychodynamic therapists considered the work of other models and looked to shorter treatments, with the therapist more focused on core conflicts and more interventionist. Integration proper should be distinguished from eclecticism, a pragmatic stance wherein therapists utilise whatever techniques they think may be useful (cf. Albeniz and Holmes, 1996). To ensure viable integration, argued Arkowitz and Hannah (1989), the relationship between behaviour, cognitive and psychodynamic therapies must be explored empirically. Goldfried and Safran (1986) in noting the numerous

theoretical differences between these therapies argued for conceptual analyses of lower level concepts important in creating therapeutic change. Later Goldfried (Wolfe and Goldfried, 1988) pointed to the need to develop instruments to operationalise key concepts. Transference is one such concept.

1.2 Transference in the Psychological Therapies

Psychodynamic psychotherapy operates on the premise that current difficulties are derived from disturbances in earlier relationships. Primary patterns of relatedness are learnt from interaction with the main caretakers in childhood. These experiences are internalised and structure experiences later in life. Psychodynamic psychotherapy facilitates the development of a significant relationship that revives earlier relationship difficulties. In general, the therapist refuses to re-enact the complementary role which is unconsciously assigned to them by the patient which throws the internalised experiences, and expectancies derived from them into relief. The therapist places the patient's current problematic relationships, especially with the therapist, in the context of earlier problematic relationships and thereby highlights the maladaptive character of them. Analysis of this transferential patient-therapist relationship is seen as the cornerstone upon which change occurs. However, as Bird (1972) suggests, 'what the substance of this central position consists of ... is something of a mystery, for, in my opinion, nothing about analysis is less well known than how individual analysts actually use transference in their day-to-day work with patients' (p.271).

But what is meant by transference ?

Laplanche and Pontalis (1973):

> The reason it is so difficult to propose a definition of transference is that for many authors the notion has taken on a very broad extension, even coming to connote all the phenomena which constitute the patient's relationship with the psychoanalyst. As a result the concept is burdened down more than any other with each analyst's articular views on the treatment - on its objective, dynamics, tactics, scope, etc. The question of the transference is thus beset by a whole series of difficulties which have been the subject of debate in classical psychoanalysis (p.456).

Because each analyst's understanding of transference is derived, variably, from their own analysis, the nuances of the concept will vary between analysts. In a much quoted definition Greenson (1965) wrote that transference involves:

> Experiencing feelings, drives, attitudes, fantasies and defences toward a person in the present which are inappropriate to that person and a repetition, a displacement of reactions originating in regard to significant persons of early

> childhood. I emphasise that for a reaction to be considered transference it must have two characteristics : it must be a repetition of the past and it must be inappropriate to the present (p.156).

In common with other definitions of transference however, Greenson's raises as many questions as it answers. For example, if transference is inappropriate what is its relationship with reality ? Must it be derived from conflictual early childhood relationships and is it an exact repetition of them (cf. Freud's, 1905, Dora case), can one reconstruct significant early childhood relationships from an examination of the here and now transferential patient-therapist relationship ? Is the patient aware of it ? These questions wait to be addressed empirically with Fenichel's (1941) observation "...it is amazing how small a proportion of the extensive psychoanalytic literature is devoted to technique and how much less to the theory of technique" (p.98) remaining of relevance today.

Esman (1990) noted that:

> the meaning, the therapeutic use, and even the theoretical explanation of transference and transference phenomena have undergone significant changes over the years. The transference has become a sort of projective device into which each commentator pours the essence of his or her approach to the clinical situation and to the understanding of that unique interactional process that constitutes the analytic situation (p.2).

With this evolution over time of the concept of transference Mollon (1997) notes that 'after a hundred years of psychoanalysis, there is much variation in both theory and practice' (p.175); Cooper (1987) notes 'I am not sure there has ever been a simple official definition of the term. While a certain flexibility of definition makes conversation possible in a field of diverse views, that we may never be clear on what any two people mean when they use the term is a significant handicap to our discourse' (p.79). Thus, for example, although transference is considered part of the patient-therapist relationship in psychodynamic therapy, there are disparate views on transference process. Freud (1913) believed transference was present from the beginning of treatment and Luborsky (1990) that it evolved as treatment progressed. Graff and Luborsky (1977) found in 'successful cases' that transference ratings were high at the end as well as the beginning of treatment. They argued that at the start of therapy these high ratings consisted of low explicit and high implicit ratings; explicit ratings being of clear overt transference references whereas implicit ratings needed to be inferred by the rater because they were of covert references, the patient either being unaware of their transferential significance or disavowing it. By the end of therapy transference ratings remained high but now consisted of low implicit ratings and high explicit. This transformation of latent transference to manifest transference reflected the primary mutative process of psychodynamic psychotherapy, bringing into consciousness the unconscious material underpinning patients' problems: "interpretation is at the heart of Freudian doctrine and technique.

Psychoanalysis itself might be defined in terms of it, as the bringing out of the latent meaning of given material." (Laplanche and Pontalis, 1973, p.227). Patients enact their problems and defences against them within the patient-therapist relationship. Exploration around this allows interpretation pointing to the latent meaning of patients' experiences thereby bringing the unconscious material into consciousness allowing increased patient awareness of it and control and re-adjustment.

Although Freud attempted to maintain a unitary theoretical structure for psychoanalysis, it is noted above that in his lifetime and subsequently a theoretical pluralism developed and with it a heterogeneity about the concept of transference; a heterogeneity not just across schools of psychoanalysis (e.g. Freudian and Kleinian) but also within particular theorists views across time, including those of Freud himself.

One framework for considering this heterogeneity may be provided by considering the three 'groups', Freudian (and Neo-Freudian), Kleinian and Object Relations.

1.2.1 On Freud and Transference

Freud's awareness of transference and his understanding of its significance in the consulting room evolved gradually. He wrote infrequently on the subject, predominantly before 1917 and, argued Bird (1972), without "the high level of analytical thought which has come to be considered as standard for him." (p.268). He first used the term in *Studies on Hysteria* (1895) which he co-authored with Breuer. Breuer was so shocked by a female patient, Anna O, falling in love with him and by her repressed sexual material that he stopped treating her. Freud, however, decided to study the phenomenon and utilised the term transference to describe what he saw as the false connection between a person who was an object of earlier wishes and the analyst. In 1883 when Freud and Breuer first discussed Anna O they saw transference as an obstacle to therapeutic work. By 1895 when Studies on Hysteria was published Freud considered the obstacle could be overcome by making the patient conscious of the false connection. He also saw a role for using patients' transferential positive affect and loyalty to cajole them into overcoming resistance to what he saw at that time as the central psychoanalytic process of recollection of early traumatic events.

Freud had acknowledged that patients may hold not only extreme positive but also extreme negative feelings toward the analyst. It was not, however, until his Dora case in *Fragment of an Analysis of a Case of Hysteria* (1905) that he acknowledged the importance of these negative feelings. The centrality of Dora's negative transference and her harsh and unexpected premature

termination of her analysis after three months required Freud to revise his view of transference. He now considered it a form of resistance in which the patient used either seduction or hostility to impede the exploration of the past, that it was a re-enactment of a specific previous relationship, and for the first time declares his conviction as to its central position as a heuristic and mutative factor in analytic treatment. Thus he described transference as:

> New editions or facsimiles of the impulses and phantasies which are aroused during the progress of the analysis; but they have this peculiarity, which is characteristic of their species, that they replace some earlier person by the person of the physician. To put it another way : a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment.....by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that (Freud, 1905, p. 157).

Although transference is usually referred to as inappropriate, this definition suggested it could not be expressed without some connection to the present. For Freud the unconscious ideas from which transference derived could only be expressed through preconscious or conscious ideas. He had argued, for example, in *The Interpretation of Dreams* (1900) that dreams were unconscious wishes expressed through 'day residues'. Likewise, transference requires an analytic situation as a residue for the point of attachment.

There is some evidence that the importance Freud attached to transference in *Fragment of an Analysis of a Case of Hysteria* may have been a retrospective one. In his prefatory remarks to the paper, for example, he writes that '.. the factor of 'transference', which is considered at the end of the case history, did not come up for discussion during the short treatment' (p. 13) and in the paper's postscript, which documents, rather than the body of the paper, the new found importance Freud attaches to transference, he writes of Dora's transference that it was '.. a part of which I was in ignorance' (p.160). Four and half years elapsed between the paper being first accepted for publication and its subsequent appearance. During this period, it may be argued, that Freud, through reflecting on his treatment of Dora, his self-analysis, and through reflecting on his emotive friendship with Fliess a physician colleague, came to more fully understand the significance of transference; of how early life relationships can impact on and structure later experiences. He came to perceive that with Dora he had 'neglected the precaution of looking out for the first signs of transference' (p.160) in which she had *'acted out* an essential part of her recollections and phantasies' (p.161); oedipal feelings of infatuation and anger with her father and a family friend Herr K and that he did not recognise his countertransference to Dora's enactment. His self analysis in the late 1890s revealed to him childhood memories and fantasies of his own oedipal infatuation with his mother and jealousy of his father and his death wishes against his younger brother, and

their enduring impact on current life including the conflictual roots of his closeness to Fliess. As Gay (1988) notes:

> Freud imposed on Fliess a role akin to a psychoanalyst. Freud's prolonged failure, his virtual refusal, to appraise his intimate friend realistically hints that he was caught in a severe transference relationship... He poured out his innermost secrets to his Other in Berlin, on paper and, during their carefully prearranged, eagerly anticipated "congresses" in person..... Fliess was the man Freud could tell everything. And he did tell Fliess everything.... (p.58).

The importance Freud attached to transference throughout the rest of his life varied, as did the specificity of his conceptualising of it. On occasions, and at the extreme, he referred to it as no more than patient-analyst rapport and as of benefit when positive and a nuisance when negative. After his consideration of transference in *The Interpretation of Dreams* and in the Dora case Freud did not comment further on the subject for some years. It was not until 1912, three years after Ferenczi's *Introjection and Transference* (1909), the first published paper devoted to transference, that Freud returned to the subject again in *The Dynamics of Transference* (1912). In this he expounded two categories of transference: of positive feelings and of negative feelings. Positive transference divided into i) friendly and affectionate feelings and ii) infantile longings and erotic wishes. Friendly feelings were conscious and an 'unobjectionable positive transference' derived from them, what would now be called the 'working alliance', which Freud considered necessary for a successful outcome to therapy. Negative feelings and erotic wishes were repressed and thus unconscious and used in the service of resistance; instead of remembering repressed material the patient re-enacted it towards the therapist, "the transference-idea has penetrated into consciousness in front of any other possible associations *because* it satisfies the resistance" (p.103, emphasis in original). At this time, Freud introduced the concept of the "stereotype plate", which sets the pattern of an individual's relationships and into which the analyst is assimilated:

> ...each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years ... produces what might be described as a stereotype plate (or several such), which is constantly repeated - constantly reprinted afresh - in the course of the person's life... (Freud, 1912, p.99).

However, his working model, rather than being an object relational one, was primarily economic so that he saw the therapeutic task of transference interpretation to be the freeing of libido which had been withdrawn from consciousness and reality and invested in neurotic symptoms. In *Beyond the Pleasure Principle* (1920) Freud considered the re-enactment of repressed material a consequence of the 'compulsion to repeat'; repeated either i) because of a self destructive wish or

ii) to master an old traumatic situation. In *The Question of Lay Analysis* (1926a) he argued that transference allowed a reconstruction of infantile feelings thereby revealing the 'kernel of intimate life history'. From his initial position of seeing transference as an inevitably occurring nuisance which obstructed therapeutic work he moved over time to see it played 'a part scarcely to be overestimated in the dynamics of cure' (1923, p.247), and that it was a .."universal phenomenon of the human mind ... and in fact dominates the whole of the person's relations to his human environment" (1925, p.42).

The classical (Freudian) view of transference that evolved is of displacement (cf. Laplanche and Pontalis, 1988); feelings properly belonging to an earlier relationship, instead become focused on the analyst. The analyst's task is to help patients identify conflicts expressed in the transference and refine their knowledge of the origin of these conflicts and the way they distort contemporary relationships.

1.2.2 On Klein and Transference

Freud's revision of transference, though necessitated by his experience with Dora, cannot however be fully explained by that experience. If Dora's transference was a re-enactment of a previous relationship in which she was rejected, why with Freud was she doing the rejecting? Clearly transference was not simply a historical re-enactment. Subsequent development of the concept of transference by Klein provided a supplementary explanation.

Klein worked with children as young as two, an age from which transference was considered derived. Thus Klein considered the play of her child patients not re-enactments of the distant past but of their phantasised efforts to deal with difficulties in the present. The transferences of adults were considered a re-enactment of current phantasy, as derived from difficulties encountered in the analytic situation but moulded upon earlier life experiences. That is, that the ".. patient deals with the conflicts and anxieties which have been re-activated, by making use of the same mechanisms and defences as in earlier situations" (Klein, 1952, p.433).

The classical view of transference is of the analyst as a mirror on to which the patient displaces, from childhood, unconscious wishes felt toward their parents. The Kleinian view considers the analyst a container into which internal objects, not just representations of parents but also part-object representations of infancy, and anxiety within these internal object relations, are projected (Segal, 1981). Projection is considered not only central to transference but to be at the foundation of mental functioning. Therefore Klein (1952) is explicit that every utterance in the patient-analyst

interaction has transference implications and that exploration of these will reveal defences against the anxieties produced by the transference situation. In contrast, Freudian analysts would more usually require an accumulation of utterances to present converging evidence of transference material. Thus in comparing Freudian and Kleinian analysis of transference we see that the former came to be derived from a concern with the role of the ego and the analysis of defence and the latter by the importance placed on early object relations and primitive instinctual fantasy (cf. Zetzel, 1956). Because of this Kleinian technique aims to unearth not just past relationships but also the 'current dynamic state of the patient's internal objects and unconscious fantasies' (Langs, 1976, p57). Because Kleinians consider transference operates through mechanisms which defend against early anxieties, their transference interpretations focus initially on the elucidation of material from early life, confronting defences against these early anxieties. Freudians conversely interpret 'phallic' material (three to five years of age) first, avoiding deep transference interpretations early in therapy because of concerns this may lead to premature and possibly unbearable anxiety, moving to earlier material later (cf. Frosh, 1987). Whereas the Freudian analyst represents parental figures, the Kleinian analyst may represent internal objects (mental representations of people or parts of people). The mutative process in Freudian analysis is through increased knowledge becoming available to the ego. In Kleinian analysis it is through repairing 'splits', in which the analyst's interpretations feed back to the patient projected elements of the self. For example, childhood destructive feelings towards parents are denied and projected into them. 'I hate my parents' becomes 'My parents hate me'. Within the transference the analyst is experienced as hating, but his or her behaviour and interpretations challenge the beliefs and facilitate the patient's becoming aware that the hateful feelings originate from themselves.

1.2.3 On Object Relations Theory and Transference

Freudian and Kleinian analysts have tended to rely heavily on instinctual or drive-based explanations of how people interact with the world. However, some, such as Kernberg (1976) and Sandler (Sandler and Sandler, 1978), whilst retaining classical metapsychological language have given increasing weight to the premises of Object Relations theory. In so doing they have fundamentally moved from Freud's original libido theory in which energy is removed from reality and invested in neurotic symptoms, to one in which key conflictual childhood relationships are internalised and become the basis of a structure which mediates experience of current reality. Object Relations theorists (e.g. Winnicott, 1965; Fairbairn, 1952) emphasise the need to form and maintain relationships rather than the drives of sex and aggression in explaining how people interact with the world. Transference is considered to arise from mental representations of the self

and others. These representations are formed in response to frustrations experienced within early relationships (Balint, 1968) and serve to organise recurrent affective-cognitive experiences. In considering the mutative process, Object Relations theorists place more emphasis on the need to provide a safe and caring environment, a 'genuine emotional contact' (Fairbairn, 1978), providing what may have been missing in early life, and the use of interpretations to identify, explore and resolve conflicts in the transferential relationship. Through this the individual is freed, '...from fixations created by bad relationship experiences' and encouraged to internalise the, '...more nurturant and supportive relationship with the therapist' (Frosh, 1987, p.252).

The classical Freudian psychoanalyst will wait for transference to develop into a transference neurosis wherein all the patient's wishes, fears and fantasies are focused on the psychoanalyst and are close to consciousness before making transference interpretations; "... all the libido is forced from the symptoms into the transference and concentrated there..." (Freud, 1917, p.455). In contrast Kleinian and Object Relations psychoanalysts will make transference interpretations from a patient's first session because they see transference as the unconscious and omnipresent persistence of infantile patterns of relating and/or the defences against them.

1.2.4 Summary of the Conceptual Diversity of Transference

In summary, rather than being a unitary concept transference may be seen as '....several concepts that unfolded over the course of more than a century' (Hinshelwood, 1990, p.446): namely, i) an unwanted event; ii) something the analyst may use to overcome the patient's resistances to psychoanalytic exploration; iii) a form of resistance used by the patient to inhibit the psychoanalytic process; iv) a re-enactment of a previous relationship allowing reconstruction of childhood history; v) an enactment of current unconscious phantasy stimulated by the difficulties of the analytic session; vi) an enactment with the analyst of internal object relations.

In view of this apparent conceptual diversity any empirical investigation of transference needs to state explicitly its defining characteristics.

1.3 Conceptual Analysis of Transference I

Given the conceptual diversity of transference, an operational definition of it for use in the present research was reached by identifying the shared elements used in definitions of transference.

A literature search using PsycLIT and the library of the British Association of Psychotherapists (which contains one of the largest collection of psychoanalytic texts in the United Kingdom) identified 44 definitions and these are listed in full in Appendix 3. By way of example definitions are given beneath from each of the groups, Freudian, Kleinian and Object Relations, which were used earlier in this chapter as a framework to consider the heterogeneity of transference.

Freudian

Freud (1905) "New editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another away: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These then - to keep to the same metaphor - are merely new impressions or reprints. Others are more ingeniously constructed; their content has been subject to a moderating influence.....by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that. These, then, will no longer be new impressions, but revised editions." (pp.157-158).

Freud (1912) "It must be understood that each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life. ....This produces what might be described as a stereotype plate (or several such), which is constantly repeated - constantly reprinted afresh - in the course of the person's life. ..... Thus it is a perfectly normal and intelligible thing that the libidinal cathexis of someone who is partly unsatisfied, a cathexis which is held ready in anticipation, should be directed as well to the figure of the doctor ... the cathexis will introduce the doctor into one of the psychical "series" which the patient has already formed." (p.99).

Kleinian

Grotstein (1981) "transference occurs as a projective identification of aspects of the self (including the displacement of past projective identifications) in the present into or onto the figure of the analyst." (p.137).

Segal (1981) "... all aspects of the patient's communications in a session contain an 'element of unconscious phantasy', even if they appear to be concerned with external facts." (p.79).

Object Relations

Sandler (1976) "Transference need not be restricted to the illusory appreciation of another person...., but can be taken to include the unconscious (and often subtle) attempts to manipulate or provoke situations with others, which are a concealed repetition of earlier experiences and relationships." (pp.35-36).

Lower, Escoll, Little and Ottenberg (1973) "... a revival of attitudes and feelings originally belonging to relationships with figures in the patient's early life and expressed toward current objects, in particular the analyst." (p.738).

A conceptual analysis was undertaken of the 44 definitions of transference identified. The process of the conceptual analysis involved identifying the key components of each transference definition. A list of all key components so identified was then drawn up and from this a list of basic concepts distilled under which all the key components could be subsumed. This process of distillation was continued until primitives were reached. The concept of a 'primitive' is analogous to the idea of a 'semantic primitive', identifiable in conceptual analyses of lexical terms. Thus, for example, Miller and Johnson-Laird (1976) argue that the concept 'red' is a semantic primitive because it cannot be usefully further semantically divided. By analogy therefore it is argued that terms such as 'therapist', 'parent', 'feeling' and 'conflict', are basic concepts in the analysis of definitions of transference. This process of conceptual analysis was undertaken independently by the author and by a Consultant Clinical Psychologist with a national profile for his published work on psychotherapy and on psychoanalytic constructs. They then conjointly identified a consensual ground of 13 'primitives' (see Tables 1.1 and 1.2):

i) Conflict - derived from conflict, intrapersonal or interpersonal
ii) Inappropriate - not fully appropriate to the present
iii) Past - derived from past experience
iv) Parent - derived from the relationship with parents
v) Therapist - refers to the therapist/therapy
vi) Lack of awareness - patients' lack of awareness of their transference
vii) Attitude - the transfer of attitudes
viii) Behaviour - the transfer of behaviour
ix) Feeling - the transfer of feelings
x) Thoughts/Ideas/Memories - the transfer of thoughts, ideas or memories
xi) Wishes/Impulses - the transfer of wishes or impulses
xii) Fantasy/Phantasy - the transfer of fantasies or phantasies
xiii) Instinct - derived from instincts

Table 1.1 Conceptual Analysis of Transference Definitions - Part One

	Conflict	Inapprop.	Past infancy	other	Parent	Therap.	Lack of awareness
Freud (1895)		*				*	
Freud (1900)	*						*
Freud (1900)			*			*	
Freud (1905)		*		*		*	*
Freud (1912)		*				*	*
Freud (1912a)			*			*	
Freud (1914)	*	*			*	*	*
Freud (1914a)				*		*	*
Freud (1917)		*		*		*	
Freud (1920)	*	*	*			*	
Freud (1920)	*			*		*	*
Freud (1926)	*	*		*		*	*
Freud (1933)	*	*	*			*	*
Freud, A. (1947)			*		*	*	*
Fenichel (1946)	*	*	*			*	*
Silverberg (1955)				*			
Chance (1952)			*		*	*	
Waelder (1956)			*			*	
Rawn (1958)	*			*		*	
Greenson (1965)		*	*		*		
Rosenfeld (1965)				*		*	
Crisp (1966)		*		*			

Table 1.1 Conceptual Analysis of Transference Definitions - Part One contd./1

	Conflict	Inapprop.	Past infancy	other	Parent	Therap.	Lack of awareness
Greenson (1967)		*					
Mueller (1968)	*			*		*	
Sandler et al (1970)		*	*			*	
Truax (1971)			*		*	*	
Rhoads (1972)		*		*		*	
Lower et al (1973)			*		*	*	
Luborsky et al (1973)	*	*	*			*	*
Sandler et al (1973)		*		*		*	*
Blanck & Blanck (1974)		*		*		*	*
APA (1975)	*		*				*
Langs (1976)						*	
Sandler (1976)	*	*		*		*	*
Graff (1977)		*	*			*	*
Segal (1981)	*	*				*	*
Grotstein (1981)	*						
Waterhouse (1984)		*	*			*	
Erdelyi (1985)						*	
Rycroft (1985)		*	*			*	*
Chessick (1986)	*		*			*	*
Laplanche (1988)	*		*			*	*
Olsson (1988)		*					
Curtis (1973)	*		*			*	*

Table 1.2 Conceptual Analysis of Transference Definitions - Part two

	Attitude	Behav.	Feeling	Memory/ thought	Wish/ impulse	Fantasy/ phantasy	Instinct
Freud (1895)			*	*			
Freud (1900)				*			
Freud (1900)				*			
Freud (1905)				*	*	*	
Freud (1912)			*				
Freud (1912a)		*	*	*			
Freud (1914c)		*		*			
Freud (1914g)	*			*	*		
Freud (1917)			*				
Freud (1920g)							
Freud (1920g)				*	*		
Freud (1926)	*		*	*			
Freud (1933)				*	*		
Freud, A. (1947)				*	*		
Fenichel (1946)	*		*	*			
Silverberg (1948)							
Chance (1952)	*	*	*				
Waelder (1956)				*		*	
Rawn (1958)			*	*			
Greenson (1965)	*		*	*	*	*	
Rosenfeld (1965)							
Crisp (1966)	*	*					

Table 1.2 Conceptual Analysis of Transference Definitions - Part two contd./1

	Attitude	Behav.	Feeling	Memory/ thought	Wish/ impulse	Fantasy/ phantasy	Instinct
Greenson (1967)							
Mueller (1968)			*		*		
Sandler et al (1970)	*	*	*	*		*	
Truax (1971)			*				
Rhoads (1971)	*						
Lower et al (1973)	*		*				
Luborsky et al (1973)		*	*	*		*	
Sandler et al (1973)							
Blanck & Blanck (1974)		*		*			
APA (1975)		*	*				
Langs (1976)						*	
Sandler (1976)		*					
Graff (1977)			*				
Segal (1981)						*	
Grotstein (1981)							
Waterhouse (1984)	*		*			*	
Erdelyi (1985)			*				
Rycroft (1985)			*	*			
Chessick (1986)				*			
Laplanche (1988)				*	*		
Olsson (1988)	*	*	*				
Curtis (1973)		*	*	*		*	

1.3.1 Summary of the Conceptual Analysis of Transference

The frequencies of the 13 'primitives' identified from the conceptual analysis of transference are identified in Table 1.3 and outlined in the following points:

Conflict - a conflictual origin to transference, intrapersonal or interpersonal, was referred to in 39% of definitions. References to concepts such as 'unconscious' and 'repressed' were taken to imply a conflictual basis.
Inappropriateness - Fifty-two per cent of definitions indicated that the transference was not fully appropriate. A number, however, indicated that the therapist may stimulate certain transferences, for example, Freud (1905) '..... taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that' (p. 157).
Derived From the Past - Transference was seen to be rooted in the past in 91% of definitions and 59% of these referred to childhood origins.
Derived From Relationship with Parents - Fourteen per cent of definitions explicitly referred to transference being derived from relationships with parents. Another 11% referred to relationships with significant childhood figures.
Refers to Therapist - Eighty per cent of definitions referred to transference occurring toward the therapist, 31% mentioned transference toward current significant others.
Lack of Awareness - A lack of awareness, by the patient, of transference was stated by 52% of definitions.
What is Transferred - Thirty per cent of definitions referred to the transfer of earlier *attitudes* to the present, 20% to the transfer of *behaviour*, 50% of *feelings*, 48% of *thoughts/ideas/memories*, 18% of *wishes/impulses* and 20% of *fantasies (or phantasies)*.

No definitions referred directly to transference being instinctually derived. Freudians and Kleinians however consider instinctual derivation to be implicit in terms such as wishes, phantasies and repetition compulsion, which were referred to.

Following the conceptual analysis 12 psychoanalysts and psychotherapists from the Institute of Psychoanalysis and the British Association of Psychotherapists (the leading United Kingdom training bodies for psychoanalysis and for psychodynamic psychotherapy respectively) and from the Henderson Hospital (an internationally renowned psychotherapy centre) were surveyed. All 12 found that the key components of each of the 44 definitions of transference could be encapsulated by the list of the 13 'primitives' without a need for further 'primitives'. When asked of the validity of each primitive with respect to their conceptual understanding of transference 67% questioned

the 'primitive' *instinct* and 50% the 'primitive' *inappropriate*. All other 'primitives' were considered valid.

Thus although theoretical pluralism in psychoanalysis has led to a heterogeneous view of transference the conceptual analysis suggested agreement that patients re-experience with the therapist interpersonal styles that are derived from childhood relationships with primary caretakers. Over a third of definitions identified the conflictual nature of these relationships. Whilst the therapist was identified as a recipient of transference, others were not excluded as potential recipients. Approximately half the definitions considered that transference was not wholly appropriate and that the patient was not fully aware of it. Attitudes, behaviour, feelings, fantasies, ideas, impulses, memories, thoughts and wishes were identified as being transferred.

Table 1.3. Conceptual Analysis

'Primitives'	Frequency	Percentage
Conflict	17	39
Inappropriateness	23	52
Past		
(i) Childhood	26	59
(ii) Other past	14	32
Parent	6	14
Past significant other	5	11
Therapist	35	80
Lack of awareness	23	52
Attitude	13	30
Behaviour	9	20
Feeling	22	50
Thought/idea/memory	21	48
Wish/impulse	8	18
Fantasy/phantasy	9	20
Instinct	0	0

1.4 The Focus of Therapists' Interventions

Therapist feedback is a central part of all psychological therapies and a major mutative factor. Through it patients gain insight into their behaviour, cognitions and feelings.

Goldsamt, Goldfried, Hayes and Kerr (1992) compared the focus of interventions of cognitive (Beck), cognitive-behavioual (Meichenbaum) and psychodynamic (Strupp) therapists with the

same patient. Their premise was that cognitive therapy is intrapersonal in focus, working with the effect thinking has on feelings and behaviour and teaching the identification and challenging of negative thoughts, whereas psychodynamic therapy is interpersonal in focus. The research showed that Beck focused on client thinking and that his focus was intrapersonal, addressing links between aspects of client functioning e.g. the influence of thoughts on feelings. When his focus was interpersonal it was more commonly upon how others influenced the client rather than what part the client may play in interpersonal difficulties. He also focused more on the client's partner and general others rather than on his parents or himself, the therapist. Meichenbaum and Strupp focused as much on the impact of the client upon others.

The study is interesting but is based on one client and one session. A question may therefore be asked as to the generalisability of its results.

1.4.1 Interpersonal Links

All psychological therapies make references to interpersonal relationships. However, Kerr et al (1992) found that whilst making interpersonal links was positively correlated with outcome in exploratory therapies (an approaching significant correlation as measured by improvements in self-esteem and social adjustment) there was no such positive correlation in cognitive-behavioural therapy. This finding raises the question as to what cognitive-behavioural therapists were or were not doing in making interpersonal links as compared with exploratory therapists. In considering this it is of note that in Kerr's study the configuration of attributes related to improvement in social adjustment seemed to indicate that this positive change was associated with a therapeutic focus on the patient's transferential reactions e.g. patient's self observations, the expected reaction the patient had regarding others, interpersonal links, focus on the therapist and focus on the parent (cf. Goldfried, 1996). Castonguay, Hayes, Goldfried and DeRubies (1995) attempting to replicate the findings of Goldsamt et al (1992), mentioned above, found that cognitive-behavioural therapists, when focusing on interpersonal issues, looked more at the effect others were having on the patient than on the potential contribution that clients bought to their interpersonal difficulties and when addressing persons in patients' lives therapists more often referred to patients' mates and others in general rather than to their parents or the therapist. However, the therapists were not experienced cognitive-behavioural therapists and used a manualised version of cognitive therapy.

1.4.2 A Specific Interpersonal Link - The Patient-Therapist Relationship

Shapiro (personal communication) had found a positive relationship in exploratory therapy between exploration of the patient-therapist relationship and outcome. In this he was echoing the earlier findings of Malan (1976) of a positive relationship between the linking of feelings toward the therapist and toward parents, and outcome. But Shapiro also found, as did Hayes, Castonguay and Goldfried (1996), that there was a negative relationship in prescriptive therapy between exploration of the patient-therapist relationship and outcome. So here is a specific example of the more general relationship between interpersonal links and outcome referred to above. Why the differential effect on outcome, across psychodynamic and cognitive-behavioural therapies, of focusing on the patient-therapist relationship ? Shapiro found no differential emphasis on attention to the therapist but that a focus on the parent occurred more in exploratory therapy. He also found that exploratory therapy highlighted past, early childhood, and current time frames whereas cognitive-behavioural therapy highlighted current and future time frames, and that exploratory therapy focused on emotions and expectations whereas cognitive-behavioural therapy focused more on actions. The areas identified by Shapiro as being focused on in exploratory therapy and which in turn he suggests are linked to positive outcome begin to look like transference referents. Indeed Kernberg (1973) had found that the more transference is focused on the better the therapy outcome, and Kerr et al (1992) that positive change in cognitive therapy seemed to be linked to a focus on patients' 'transferential reactions', and in the case of Hayes, Castonguay and Goldfried (1996) to exploration of early experiences to uncover core assumptions. Similarly, Jones and Pulos (1993) found the use of 'psychodynamic techniques' were associated with improvement in depression in cognitive therapy, whereas cognitive techniques showed little or no association with outcome. Is cognitive therapy more effective when the developmental context is considered ?

Olsson (1988) concluded that the way the patient-therapist relationship is understood by the therapist and how it is discussed during sessions is largely independent of outcome, with one exception. Good outcome therapists showed a better understanding of the origins of patterns which the patient repeated toward themselves and other important people in their life; they understood how childhood experiences influenced patients and led to their repeating less adaptive patterns. Olsson also found that in therapies with a good outcome, patients took the initiative to discuss the therapeutic relationship more frequently or as often as the therapist whereas in poor outcome therapies the therapist took the initiative more often.

1.4.3 Intrapersonal Links

As well as making the interpersonal links discussed above, therapists also make intrapersonal links. Researchers, for example Goldsamt et al (1992), have argued that cognitive-behavioural therapies are intrapersonal in focus, making links such as between thoughts and feelings. In contrast, exploratory therapies are seen as interpersonal in focus. Thus Castonguay et al (1995) in examining sessions of cognitive-behavioural therapy of depressed patients found therapists placed more emphasis on intrapersonal than interpersonal issues. However the view that exploratory therapies all focus more on interpersonal matters may be questioned. Classical psychoanalysis has an emphasis upon the interaction between various components of the patient's internal world (cf. Prochaska, 1979). For Freud and Klein the internal world is more important than the external interpersonal world. Cooper (1987) argues that psychoanalysts:

> ...focus primarily on the intrapsychic life of the patient, the psyche being conceived largely as driven toward objects, rather than formed and constantly reforming in relation to objects. Analysts holding this view of course acknowledge the interpersonal aspect, but they are likely to see it as part of the surround rather than a core of analytic work (p.90).

Interestingly some research suggests things are not as clear cut with cognitive-behaviour therapy either. Kerr et al (1992) found that cognitive-behaviour therapists, though making fewer interpersonal links than exploratory psychotherapists, still made more interpersonal links than intrapersonal links: in fact, there was no difference between the therapies in their tendency to emphasise intrapersonal or interpersonal links. And so the picture from research to date is not clear. In addition previous research has examined only a very small number of sessions with a small number of patients.

Recent research has pointed to further convolutions. Castonguay, Goldfried, Wiser, Raue and Hayes (1996) found in cognitive-behaviour therapy that a focus on intrapersonal factors, for example a link between distorted thoughts and negative emotions, was positively correlated to depressive symptoms post therapy! Regression analyses suggested this was accounted for by problems in the working alliance. If this is so, it points to how vital it is for cognitive-behaviour therapists to attend to both explicit and implicit material related to the patient-therapist relationship. Their analysis suggested, they say, that some cognitive-behaviour therapists dealt with strains in the working alliance by increasing their attempts to persuade the patient of the validity of cognitive-behaviour therapy and that others saw it as a manifestation of distorted thinking which needed to be challenged. Both techniques led to repeated cycles of therapist pushing and patient increased unresponsiveness. Castonguay et al suggest that most of the issues discussed in sessions

with high intrapersonal consequences and low alliance scores concerned emotionally laden, real interpersonal problems and they cite by way of example infidelity. They suggest that the therapist might better have facilitated the patient's exploration of feelings, as they found that the client's emotional experiencing and a focus on their relationship with their parents positively correlated with symptomatic improvement. Within exploratory therapies of course, a patient's raising the subject of infidelity might be considered as a potential comment on a covert dynamic of the patient-therapist relationship, for example the patient fearing being rejected by the therapist or having feelings about them seeing other patients.

1.5 Previous Research on Transference

Research on transference may be seen to have moved through three stages. In the first stage, the 'questionnaire' method, patient-therapist similarity, as perceived by the patient, was considered to be evidence of transference. In the second stage, the 'rating' method, studies investigated the degree to which independent judges agreed on the presence of transference in therapy sessions, and on what basis. More recently researchers have developed measures which appear to be the closest yet to the clinical concept of transference.

The Questionnaire Method - The questionnaire method was the first used to operationalise transference. Studies examined parent-therapist similarity as perceived by the patient. Perceived similarity was seen as evidence of transference.

Crisp (1964) defined an aspect of transference as the patient's identification of the therapist with an ideal father. He used a repertory grid technique, with elements including 'ideal father', 'like GP' and 'like therapist'. He found support for the hypothesis that patients would see the therapist like an ideal father.

Chance (1952) asked eight patients to rate a sample of feeling statements for parent and therapist. Five of the eight correlations were significant.

Although Chance and Crisp did find a perceived parent-therapist similarity, Sechrest (1962) did not. He too used a repertory grid technique and found a perceived similarity of therapist and favourite teacher/physician but not parent.

Whilst the questionnaire method is not without value, in equating transference with perceived similarity with a parent, it takes an unsophisticated view. In addition, the methodologies that were

used studied transference outside of the patient-therapist relationship in which it is expressed and participants could easily guess what was being researched.

The Rating Method - Another group of studies investigated the degree to which independent judges agreed on the presence of transference and on what basis. Such studies predominantly rated audiotaped sessions (e.g Bellack and Smith, 1965), or sessions viewed through a one-way screen (e.g Strupp, Chassan and Ewing, 1966).

Lower, Escoll, Little and Ottenberg (1973) investigated what behavioural manifestations led to the inference of transference. Judges listened to five minute segments of audiotaped psychoanalytic sessions and read transcripts of each segment. Judges then rated segments on the amount of transference present and cited evidence for their decision. The highest ratings of transference occurred in segments where affect, particularly negative, was expressed to the therapist. The judges only rated explicit transference.

Luborsky, Graff, Pulver and Curtis (1973) utilised the same audiotaped segments as Lower et al (1973) but rated both explicit and inferred transference. The correlation between judges was low ($r= 0.26$) when they rated the amount of transference present in a whole segment but was higher ($r= 0.40$) when rating the expression of transference toward a specific person in a segment.

The low degree of agreement on transference ratings in these studies suggests a need for more concretely defined common criteria for transference and judges trained in the use of the rating instrument (cf. Olsson, 1988).

Guided Clinical Judgement - Two more recently developed measures appear closer to the clinical concept of transference than those presented above.

Gill developed 'The Patient's Experience of the Relationship with the Therapist' (PERT) (Gill and Hoffman, 1982). He considered that systematic research on the psychoanalytic process, research starting from an accurate record of sessions, was still relatively uncommon. 'PERT' is a coding system for rating the frequency of communications regarding the patient's manifest experiences of the relationship with the therapist and also inferred implicit references. Transcribed psychotherapy sessions form the basis of these ratings. Gill indicates that his use of the term 'Experience of the Relationship' refers to an aspect of transference and includes resisted aspects of that relationship. The method does not consider the contents of the relationship.

Gill's system is derived from his belief that transference is more common than assumed, is not pursued vigorously enough, and that therapist behaviour contributes to it. His research focuses on disavowed 'here and now' transference feelings toward the therapist. PERT has shown itself to be potentially useful in investigating aspects of transference across psychological therapies: for example, whether different therapist behaviours across different therapies may stimulate different transferences. However only patient, not therapist utterances can be rated, these must meet stringent criteria, and no attempt is made to consider the content of communications.

The Core Conflictual Relationship Theme (CCRT) was developed by Luborsky (Luborsky, 1977; Luborsky, Crits-Christoph and Mellon, 1986). The CCRT rates not only the frequency but also the content of relationship patterns in psychotherapy. Judges examine narrative episodes in which the patient describes interactions with one main person. They rate the patient's main wishes, needs and intentions to this person, the responses from the other person and the patient's response. Within each component the types with the highest frequency across all relationship episodes are combined to constitute the CCRT. Central to the CCRT is that a patient's relationship pattern is a 'stereotype plate', like Bowlby's (1988) 'blueprint', which is repeated in new editions throughout the patient's life. This pattern should also logically be expressed toward the therapist and be traceable to the patient's early life relationship with parents. With the publication of 'Understanding Transference - The Core Conflictual Relationship Theme Method' (1990) Luborsky argued that the most likely cognate of CCRT was transference and provided substantial empirical support for his claim that CCRT corresponded with Freud's observations of transference. However, the system is not without problems; it only rates patient statements and only some of those, not all patient interactions can be characterised by wishes, needs or intentions, and transferential material is not solely expressed within narratives about interactions with one main person.

There is therefore a need for a transference coding system that may be applied to verbatim transcriptions of actual therapy sessions, which has clearly defined components and is manualised, and which may be applied to all utterances within sessions.

1.6 Summary

Why undertake research on transference ?

* This chapter has noted transference's position as an important psychological concept dating back more than a hundred years.

* It has also noted that transference is the cornerstone of psychoanalysis and psychoanalytically informed psychotherapies and that any consideration of the patient-therapist relationship in such therapies has inexorably to consider transference.

* Until recently other psychological therapies have not considered the patient-therapist relationship pivotal nor embraced the concept of transference. In recent years, some cognitive-behavioural therapists have begun to look to psychoanalytic literature in an attempt to overcome difficulties in the patient-therapist relationship experienced in working with people with severe mental health problems such as borderline personality disorder, and to broaden the explanatory power of the theories underpinning their clinical practice.

* Such integration of aspects of different psychotherapies has seemed to increase as clinicians confront the limitations of specific approaches both as part of the natural evolution of therapies but also from pressures intrinsic to healthcare contracting processes.

* It has also been noted that despite the long history of transference, its central position within psychoanalytic psychotherapies, and its integration into other therapies, research into transference is limited, both in quantity and quality.

1.6.1 Transference has been little researched

Psychodynamic therapists consider transference, expressed within the patient-therapist relationship, as the primary vehicle through which they effect change in their patients. Though more commonly viewed as a unitary concept it may be argued that transference is several concepts that have evolved over the last hundred years. There are differences between the psychodynamic schools as to the nature of transference and there have also been significant changes over time within particular key individuals' understandings of it. These differences include disparate views on the mechanisms underpinning it and transference process including on whether it is present from the beginning of treatment and what is involved in the resolution of transference as a mutative process. However, the empirical literature within the psychodynamic field on transference is slight and that from other therapies which pay less heed to the patient-therapist relationship is smaller still.

The present study was intended to throw light on the nature of transference, its process in treatment and therapist response to it across not just psychoanalytic psychotherapy but the other major psychotherapies too.

The present study also intended to improve upon much previous research by:

i) analysing verbatim transcriptions of actual therapy sessions

ii) analysing the work of therapists who were skilled in and believed in the psychotherapy they offered. Henry, Strupp, Butler, Schacht and Binder (1993) found that therapists trained in a manualised form of psychodynamic therapy produced unexpected interactional problems through their being, for example, less supportive and more defensive. This they found, in turn, correlated negatively with patient change.

iii) developing and using a transference coding instrument with clearly defined components of transference and guidelines on rating utterances, and which was shown to have high reliability. The instrument could also be applied to all narratives by both patients and therapists and allowed for the coding of both explicit and implicit references to transference components. PERT (Gill and Hoffman, 1982) does not examine the content of narratives and CCRT (Luborsky and Crits-Christoph, 1989) only codes some patient narratives; neither system codes therapist statements.

1.6.2 The Patient-Therapist Relationship

The patient-therapist relationship has been argued to be a potential mutative factor common to all of the major psychotherapies (cf. Stiles, Shapiro and Elliot,1986; Power and Brewin, 1997). One frequently cited aspect of this commonality is the therapeutic alliance (Goldfried and Padawer, 1982), a term first used by Freud (1895) who saw it as one aspect of positive transference. However, behaviour and cognitive therapies have not traditionally considered the patient-therapist relationship and problems within it as a source of learning and change. Recent research (Kerr et al, 1992) has shown that prescriptive therapists do explore the patient-therapist relationship, but that their so doing is not positively correlated with outcome whereas in exploratory therapies it is. The last quarter of the twentieth century has seen psychotherapies other than psychoanalytic psychotherapy increasingly giving consideration to the nature of the patient-therapist relationship

and its mutative potential. But the number of clinicians whose consideration of the patient-therapist relationship has been directly informed by transference has rather lagged behind this, as has its empirical investigation across the psychotherapies.

The present research into transference across psychological therapies will identify what therapists bring to bear upon the patient-therapist relationship. It aims also to provide an understanding of factors impeding and facilitating the development of therapeutic alliances.

1.6.3 Psychotherapy Integration

The integration of different psychotherapeutic approaches has become a clinical reality as therapists from different orientations confront the limitations of their specific paradigms (cf. Goldfried, 1993). Such confrontation has increased as National Health Service reforms, and their demands for proof of increasing efficiency and effectiveness take hold. Cognitive therapists have needed to focus more of their clinical time on people with severe and enduring mental health problems and evolve ways of working with their problematic core assumptions. Psychodynamic therapists have needed to provide more short term focal therapy. Both have needed to accept the growing demand from purchasers for evidence based practice. There has been a move by many cognitive therapists to incorporate, with varying degrees of acknowledgement, psychodynamic techniques and concepts (cf. schema based cognitive therapy, Young, 1994). Psychodynamic therapists, though increasingly offering shorter treatment lengths with more directive interventions, have less clearly taken up concepts and techniques from behaviour and cognitive therapies. Nonetheless there appears more openness from many to a thoughtful dialogue with other theoretical approaches (cf. Mollon, 1993).

Arkowitz and Hannah (1989) stated that to ensure viable integration there is a need to explore the relationship between behaviour, cognitive and psychodynamic therapies. In view of their numerous theoretical differences Goldfried and Safran (1986) argued for conceptual analyses of lower level concepts important in creating therapeutic change and Wolfe and Goldfried (1988) for the development of instruments to operationalise key concepts. Transference is one such concept. The author, having developed an instrument to operationalise transference then uses it in the present study to code transference as it occurs in a range of psychotherapies.

CHAPTER 2

THE PILOT STUDY*

2.1 Summary

The pilot study investigated the occurrence of references to transference components across four psychological therapies, two cognitive-behavioural (cognitive-behavioural therapy and cognitive therapy) and two psychodynamic (conversational therapy and short term psychodynamic therapy), and therapist response to it. In so doing it also considered the process of transference in treatment and the frequency of its occurrence in early and late treatment sessions. A transference coding instrument for coding patient and therapist statements in therapy sessions was constructed utilising the key components of transference identified from the conceptual analysis of transference definitions reported in Chapter One. The instrument showed good reliability in coding verbatim transcriptions of 40 therapy sessions drawn equally from each of the four therapies. The results showed patient transference references in all therapies; but these references were significantly lower in cognitive-behavioural therapies, and the psychodynamic therapies were considered the context *par excellence* of transference. Therapists in psychodynamic therapies made a higher number of transference statements and responded more fully to patient references to the therapist. The study suggests that transference does not lessen in cognitive-behavioural therapies if it is not acknowledged or recognised. There was an increase in explicit transference references in late over early sessions of all therapies. The implications of the study's findings are discussed with respect to the resolution of transference, and to patient noncompliance in cognitive-behavioural therapies.

A peer reviewed publication based on the pilot study is presented as Appendix 7.

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* Part of this pilot study was submitted as a research dissertation in partial fulfilment of the requirements necessary for the award of The British Psychological Society Diploma in Clinical Psychology.

2.2 Introduction

Freud initially saw transference as an unwanted but ever present part of the patient-therapist relationship and one which was an impediment to therapeutic progress. Over time, however, he came to consider that transference played "a part scarcely to be overestimated in the dynamics of the process of cure" (1923, p.247). In Chapter One it was noted that psychodynamic therapies have continued to consider transference as inexorably a part of the patient-therapist relationship and this relationship as the primary vehicle of change, "the single most important precondition to success" (Waterhouse and Strupp, 1984, p.77). It was also noted in Chapter One that other therapies have tended to see the patient-therapist relationship as less pivotal. Morris and McGrath (1983) in reviewing the patient-therapist relationship in behaviour therapy concluded that the relationship, unless there was treatment noncompliance, did not significantly influence treatment outcome. Even in the case of noncompliance, argued Wachtel (1982), few behaviour therapists utilised psychoanalytic concepts. This despite Freud's (1912) argument that ".. transference emerges as the most powerful resistance to (the) treatment" (p.103) and the empirical support provided by both Crisp (1966) and Rhoads and Feather (1972) for the presence of transference in behaviour therapy. There has thus been a case for further empirical consideration of the presence of transference within non-psychodynamic therapies and the part it may play in creating difficulties, including of noncompliance, in the patient-therapist relationship. But with transference research very limited amongst psychoanalytically informed therapies it is not suprising that there is even less research on transference amongst therapies which do not consider the patient-relationship to significantly influence outcome.

Behaviour therapy has not generally considered noncompliance and other aspects of the patient-therapist relationship a source of learning and change. However, as noted in Chapter One, some cognitive therapists have now begun to explore the patient-therapist relationship and the underlying schemata influencing patient behaviour within it. This exploration by therapists has often been a response to the difficulties they have encountered in utilising conventional cognitive therapy with borderline patients whose pervasive interpersonal difficulties impede the formation of a working alliance. Thus, for example, Young and Lindemann (1992) evolved a 'schema focused model' of cognitive therapy and Linehan (1993) Dialectical Behaviour therapy through their experiences of the therapy interfering behaviours of patients.

However, a decade after Power (1989) had argued that cognitive therapy had not offered a substantive theoretical framework from which to tackle schemata such as those underpinning patients' interpersonal difficulties, Ryle (1998) was restating the same. He argued that the newly developed cognitive-behavioural model of Young and Lindemann offered only an elementary structural hypothesis' (p.48) and that Linehan's (1993) 'does not offer any way of making sense ..... of underlying processes and structures' (p.50) including of how early life experiences may mediate current life experience. The concept of transference and psychoanalytic metapsychology does offer the possibility of addressing Power's and Ryle's' concerns. But transference has until late been no more considered in cognitive therapy than behaviour therapy even though the views of cognitive theorists such as Guidano and Liotti (1983) exemplified that a cognitive model of transference was clearly feasible (cf. Mallinger, 1974). Guidano and Liotti's work shows similarities with that of the psychoanalyst Bowlby (1988); the former write of schemata as preconscious and derived from early childhood experiences and the latter of an unconscious internal world which influences current experience and is created in early childhood from experiences with external reality. The concept of schemata may be equated with that of the internal world and like the internal world, the well spring of transference, schemata may be inexorably linked with transference. Even when transference has, as in recent years, been incorporated into cognitive-behavioural models such as Young and Lindemann's (1992), Linehan's (1993) and Safran and McMain's (1992) who more explicitly incorporate Bowlby's work in their integrative model, there has been doubt, as expressed by Ryle (1998), as to how much it 'has been adequately understood and managed' (p.51).

These recent developments in cognitive-behavioural therapies make all the more pertinent and necessary the empirical consideration of the occurrence of transference in psychological therapies and of how therapists work with it.

2.3 The Transference Coding System

In Chapter One it was argued that rather than being a unitary concept transference was, as Hinshelwood (1990) had noted, '... several concepts that unfolded over the course of more than a century' (p.446). It was also argued that because of this conceptual diversity any empirical investigation of transference needs to state explicitly its defining characteristics. An operational definition of transference was therefore reached by identifying the shared elements used in 44 definitions of transference identified in a literature search, as described in Chapter One. A conceptual analysis of these definitions identified 13 'primitives' :

i) Conflict - derived from conflict, intrapersonal or interpersonal
ii) Inappropriate - not fully appropriate to the present
iii) Past - derived from past experience
iv) Parent - derived from the relationship with parents
v) Therapist - refers to the therapist/therapy
vi) Lack of awareness - patients lack of awareness of their transference
vii) Attitude - the transfer of attitudes
viii) Behaviour - the transfer of behaviour
ix) Feeling - the transfer of feelings
x) Thoughts/Ideas/Memories - the transfer of thoughts, ideas or memories
xi) Wishes/Impulses - the transfer of wishes or impulses
xii) Fantasy/Phantasy - the transfer of fantasies or phantasies
xiii) Instinct - derived from instincts

The concept of a 'primitive' corresponds to that of a 'semantic primitive' utilised in conceptual analyses in lexicology. Miller and Johnson-Laird (1976), for example, argue that the concept 'red' is a semantic primitive because it cannot be usefully further semantically divided. By analogy it is argued that terms such as 'therapist', 'parent', 'feeling' and 'conflict', are basic concepts in the analysis of definitions of transference.

From the conceptual 'primitives' identified a system for coding narratives was drawn up listing transference components the patient or therapist could refer to. The 'primitives' inappropriate (ii) and instinct (xiii) were excluded from the system given the question of their validity that arose from a survey of psychoanalysts and psychotherapists (see page 26). All other 'primitives' were represented. The coding system consisted of:

a) primitives that could be *experienced* - primitives vii. to xii.
b) the *time frame* of the experience - current to the therapist, and past or childhood (the two sections of the primitive past iii.)
c) *who* they could be experienced with - therapist (primitive v.), and parent or past significant other (the two sections of the primitive parent iv.)
d) *conflict* (primitive i.) about these experiences

Seven transference components the patient or therapist could refer to were listed in the system: therapist, parent and past significant other, conflict, and the agglomerated experiences in a current,

a past and a childhood time frame. An eighth component referred to the lack of awareness by the patient of the transferential aspects of their relationship with the therapist. The coding system, presented in Table 2.1, therefore identified each of the seven listed components as potentially explicit or implicit; implicit references to components needing to be inferred by the rater. For example, if we consider the statement by a patient 'When I went to confession yesterday I thought the priest must get overladen with peoples' problems. Afterwards I felt guilty about it' it refers explicitly to a current feeling involving the priest. The rater may also infer that the reference to the priest and confession is an implicit reference to the therapist and therapy.

Thus the following references, implicit or explicit, could be coded: to therapist or therapy, to past significant other, to parent, to current feeling/thought/behaviour/attitude, to past feeling/thought/ behaviour/attitude, to childhood feeling/thought/behaviour/attitude and to interpersonal or intrapersonal conflict.

An expert validity check was undertaken to ascertain consensus as to the validity of the Transference Coding System. The check took place in two stages. In stage one participants were sent the developed Transference Coding System for comment, along with the transference definitions and the results of the conceptual analysis. In the second stage participants received back their comments from the first round and the overall responses of the whole participating group (the 12 psychoanalysts and psychotherapists surveyed as part of the conceptual analysis of transference definitions (see page 26)). They were asked to reflect on both their previous comments and those of the overall group before commenting a second time.

In stage one 75% of participants considered it was unnecessary to include the reference to past, as opposed to childhood feelings, in the coding system and 67% that it was unnecessary to include the reference to past significant other as opposed to parent/caretaker. In stage two these percentages increased to 92% and 75% respectively. The majority of transference definitions in the conceptual analysis that referred to the past referred specifically to childhood and to experiences involving primary caretakers rather than, more generally, past significant others. In view of this and the outcome of the expert validity check, references about past, but not childhood feelings, were excluded as were references to past significant others who were not caretakers (throughout the remainder of the thesis the terms *past feeling* and *childhood feeling* are used interchangeably to refer to a childhood feeling). As a result an abbreviated version of the coding system was produced with a tally of components 1e, 3e, 4e, 6e and 7e which coded explicit references and 1i, 3i, 4i, 6i and 7i which coded implicit references.

Table 2.1. Transference Coding System

	Explicit	Implicit
Reference to therapist or therapy	1e	1i
Reference to past significant other (other than primary caretaker)	2e	2i
Reference to caretaker (usually parent)	3e	3i
Reference to current feeling/thought/ behaviour/attitude etc.	4e	4i
Reference to past feeling/thought/ behaviour/attitude etc.	5e	5i
Reference to childhood feeling/thought behaviour/attitude etc.	6e	6i
Reference to interpersonal or intrapersonal conflict	7e	7i

A preliminary investigation rated verbatim transcriptions of a range of cognitive-behavioural, cognitive and psychodynamic therapies in order to provide general guidelines on rating statements and to identify criteria for assigning codes in unclear cases. These guidelines (Appendix 5) stressed that each statement was to be rated separately, i.e. without reference to preceding or subsequent statements, for explicit and implicit references to transference components.

The transference coding system is applied by way of example to the following sample statements by patients:

I feel happy.	4e
I felt happy after the last session.	1e 4e
I am beginning to question the way we talk about things.	1e 4e 7e
I am furious you kept me waiting. You are just like my father. You don't care about me, it's just a job to you.	1e 3e 4e 7e
I have never trusted authority figures after the way my parents treated me as a kid. I used to wish them dead.	1i 3e 4e 6e 7e

and statements by therapists:

Perhaps it's not just your teachers at school that you're angry with.	1i 4e 7e
I think you feel angry with me too.	1e 4e 7e
I think you feel angry with me. Perhaps since being an infant you have felt like that toward people you think should look after you.	1e 3i 4e 6e 7e

2.3.1 Reliability of the Transference Coding System

One hundred patient statements each paired with the therapist's response to them were taken equally from across the four groups studied in the pilot study. These 200 statements were selected using a stratified random sampling technique. The forty verbatim transcriptions of therapy sessions researched in the pilot study were stratified by type of therapy so that there were four strata (cognitive-behaviour, cognitive, conversational and psychodynamic) with 10 sessions in each. Every patient statement in each stratum was sequentially numbered. A sample of 50 patient statements each paired with their therapist's response was then randomly drawn from each stratum using a computerised random number generator. The statements, previously rated by the author, and exhibiting a wide range of codings, were then rated by an independent rater, an experienced Consultant Clinical Psychologist, who was trained in the use of the coding system. This training included conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings of transcriptions not used in the study followed by discussion meetings with the author. At the time of rating this independent rater had more than 10 years post qualification experience of undertaking psychological therapy with adults with mental health problems. He was also in the latter stages of an eight year training in psychoanalytic psychotherapy with the British Association of Psychotherapists, where he subsequently qualified. As part of this training he had received substantial didactic teaching on psychoanalysis including on transference, and was in therapy with and clinically supervised by psychoanalysts of international renown who worked at a National Health Service centre of excellence for psychotherapy.

The transference coding system showed good reliability with a high percentage agreement between raters obtained on all components, explicit and implicit, of the system. Explicit references tended to show a higher agreement between raters, with references to the therapist showing 94% agreement, to parents 99%, to current feeling or thought 82%, to childhood feeling or thought 99% and to interpersonal or intrapersonal conflict 90%. Implicit references to the therapist showed a 75% agreement, to parents 97%, to current feeling or thought 82%, to childhood feeling or thought

91% and to interpersonal or intrapersonal conflict 84%. These percentage agreements are shown in Table 2.2. The lower percentage agreements between raters on implicit references may be explained by the degree of inference required in making such ratings. Though lower they nonetheless fall within acceptable levels of interrater agreement. So too do the generally lower agreements on rating both explicit and implicit references to current feelings and to conflict, and which may be explained by the importance of non-verbal behaviour in communicating emotion. The transcriptions rated did not give information about facial expression, gesture, body posture, tone of voice or any of the other non-verbal behaviour used in every day and which communicate emotional state (cf. Argyle, 1984).

Psychoanalysis operates within a different paradigm to empirical psychology and traditionally has relied on clinical case study to advance rather than an empirical route. From Freud (1920) to the present day it has repeatedly rejected challenges (cf. Grunbaum, 1984) to its scientific basis. These challenges arise because its database sets it apart from the objectively verifiable data demanded by the physical sciences; for although psychoanalysis does deal in part with objective data it is defined by its subjective investigation of private experience. Analysts use their own introspections, finely tuned by personal analysis and training, to introspect vicariously their analysands' psyches. Truly psychoanalytic data must include subjective data.

Table 2.2 Percentage Agreements between raters on components of the transference coding system

Components	Code	Explicit	Implicit
Reference to therapist or therapy	(1)	94	75
Reference to caretaker (usually parent)	(3)	99	97
Reference to current feeling/thought/ behaviour/attitude etc.	(4)	82	82
Reference to childhood feeling/thought/ behaviour/attitude etc.	(6)	99	91
Reference to interpersonal or intrapersonal conflict	(7)	90	84

There have therefore been methodological problems to face in developing a reliable and valid measure of transference. As an observer outside of the consulting room, one cannot directly access the subjective dataset available to the therapist and therefore one loses some of the richness of the transferential relationship. It is only possible to access directly the objective manifestations of patients' transference and therapists' responses to it. Nonetheless the transference coding system

developed is a manualised instrument which can go beneath the immediate content of patients' and therapists' utterances and reliably rate their implicit content.

In the pilot study the transference coding system was used to analyse verbatim transcriptions of taped cognitive-behavioural, cognitive, conversational and short term psychodynamic therapy sessions. It was hypothesised that references to transference components would occur in all the therapies but that psychodynamic therapists would respond more often to such statements with transference references than would therapists in other therapies. It was therefore expected that explicit references by patients to transference components would occur less in cognitive-behavioural and cognitive therapies because their presentation would not be commented on. It was also hypothesised that references to transference components would occur with equal frequency in late and early sessions of the psychodynamic therapies but that implicit references would occur less frequently because one objective of the psychodynamic therapist is to make implicit material explicit.

2.4 Method

2.4.1 Participants

Five therapists participated in the study. All were highly experienced clinical psychologists with nationally recognised expertise in the respective cognitive-behavioural and psychodynamic therapies they offered in this study.

Therapist A was a Consultant Clinical Psychologist and qualified Psychoanalytic Psychotherapist with more than 15 years post qualification experience in the National Health Service undertaking psychotherapy with adults. His specialist psychotherapy training had included many years of teaching and reading on psychoanalysis, supervised clinical practice and a personal training analysis, and he was accredited by the British Confederation of Psychotherapists, the most stringent of the psychodynamic psychotherapy regulatory bodies. He was a departmental Head of Psychology with a national reputation for his published work on clinical psychology and psychodynamic psychotherapy and for his theoretical and clinical expertise in psychodynamic psychotherapy. He was working at a centre of excellence in psychodynamic psychotherapy and was in supervision with psychoanalysts from the Institute of Psychoanalysis, London, where he subsequently completed a training.

Therapist B was a Consultant Clinical Psychologist with 10 years post qualification experience in treating adult patients in the National Health Service with cognitive therapy. In addition to the training he had received in cognitive therapy as a psychologist he had also undertaken significant post qualification training including teaching and reading on cognitive therapy and supervised clinical practice. He was supervised on all sessions used in this study by a clinical psychologist trained at the Center for Cognitive Therapy, Philadelphia, the leading international training organisation in cognitive therapy, and he himself was in and subsequently completed a training there. He was working in a centre of excellence in cognitive therapy and had a national profile for his teaching on cognitive therapy.

Therapists C, D and E were all Consultant Clinical Psychologists with international reputations from their research work on psychotherapy. Therapist C had 17 years post qualification experience in the National Health Service treating adults with psychotherapy, and therapists D and E about 6 years each. All had received post qualification training in both cognitive-behavioural and psychodynamic therapy. This training including teaching and reading on psychotherapy, and supervised clinical practice on at least 32 complete treatments of cognitive-behavioural therapy and 32 complete treatments of psychodynamic psychotherapy. To ensure adherence to treatment protocols all underwent manualised training and weekly peer supervision, before and during treatment sessions analysed in the pilot study. Adherence to protocol was also confirmed by checking verbal-response mode usage of therapists (Hardy and Shapiro, 1985).

Audiotaped and videotaped sessions of 19 patients were utilised. Demographic and diagnostic data on these participants were not sought. All were adults who appeared to be suffering from relationship difficulties, anxiety and/or depression.

2.4.2 Design

The research utilised a mixed between subjects and within subjects design.

It must be noted that the unit of analysis in the pilot study was the particular therapist-patient pair rather than the specific therapist or the patient. For this unit of analysis there was one between subjects factor, the type of therapy, for which there were four levels, and one within subject factor, session number, for which there were two levels (early or late). The four levels of the type of therapy factor were: group 1-cognitive therapy, group 2-cognitive-behavioural, group 3-Hobson's conversational therapy and group 4-short term psychodynamic therapy. If the therapies are considered separately, then, group 1 consisted of therapist B and two sessions of each of five patients; group 2 of therapists C and D and two sessions of each of five patients; group 3 of

therapists C and E and two sessions of each of five patients; and group 4 of therapist A with two sessions of each of three patients and four sessions of one patient. Thus there were 10 sessions, five early and five late, in each of the four groups.

The interventions of all four groups were of between 10 and 16 sessions.

2.4.3 The Therapies

Group 1: Cognitive Therapy

This method, based on Beck's (Beck et al., 1979) model of cognitive therapy, views psychological difficulties as frequently resulting from habitual errors in thinking. Therapy aims to restructure dysfunctional cognitions, through for example eliciting and challenging negative automatic thoughts, and behavioural experiments. The patient and therapist work collaboratively to relieve symptoms and learn more effective ways of dealing with the patient's difficulties. Sessions typically focus on the here and now and how problems are maintained, rather than the origin of these problems.

Group 2: Cognitive-Behavioural Therapy

This method (see Shapiro and Firth, 1987) focuses on patient behaviour outside of sessions and the provision by the therapist of self-management strategies for application by the patient. These strategies include: anxiety control training (Snaith, 1974), self-management procedures (Goldfried and Merbaum, 1973), cognitive restructuring (Beck et al., 1979), and a 'job strain' package (Hackman and Suttle, 1977) to reduce stress at work.

Group 3: Conversational Therapy

This method (see Shapiro and Firth, 1987), based on Hobson's (1985) Conversational Model, assumes patients' problems arise from disturbed significant personal relationships. It aims to create a patient-therapist relationship within which interpersonal problems are revealed, explored, understood and resolved. The therapist focuses on the experience of the patient in therapy and makes connections between this and other experiences of the patient, suggesting reasons for the patient's experiences and behaviour.

Group 4: Short Term Psychodynamic Psychotherapy

This method (see for example Malan, 1976) focuses on bringing into consciousness unconscious conflicts thought to underlie the patient's problems. These conflicts are considered to be re-enacted

in the transferential patient-therapist relationship. The therapist early in treatment identifies the patient's core conflict and focuses on this, interpreting signs of it and its past origins in the patient's manifest behaviour, particularly that displayed in sessions. This knowledge is considered to facilitate the patient gaining mastery over the conflict.

2.4.4 Procedure

i) Obtaining audiotapes and videotapes

More than 100 individuals and institutions from six countries were identified because of their expertise in one of the major psychological therapies i.e. behaviour, cognitive-behaviour, cognitive, interpersonal/conversational, psychodynamic and psychoanalytic. These individuals and institutions were then approached by letter. The letter explained that research was being undertaken on 'the interaction of patient-therapist pairs in psychotherapy sessions' and enquired of the possibility of access to existing audiotapes or videotapes of sessions of their treating patients with the therapy in which they were a specialist. A number of positive responses were received requesting further information. This was furnished through telephone conversations, further letters and through face to face meetings. The nature of the research was explained to all potential therapists and their willingness for their work to be researched was obtained. Agreement was secured for access to approximately 150 audiotaped and videotaped sessions of complete treatments across cognitive-behaviour, cognitive, conversational and psychodynamic therapies. Each of these tapes was of naturally occurring therapy of patients being treated in the National Health Service. None were of therapies specially conducted for this research. All treatments were delivered by a specialist therapist experienced and qualified in the therapy they offered. Thus, for example, therapist A (see page 45) was a recognised expert in psychodynamic psychotherapy, only worked in this theoretical model, and was based in a National Health Service specialist treatment centre where only psychodynamic psychotherapy was available. Therapist B was a recognised expert in cognitive therapy, only used this theoretical approach, and worked at a National Health Service specialist treatment centre where only cognitive therapy was available. All tapes involved patients who had given consent for recordings of their treatment to be used for research purposes. The confidentiality of information used in the research was preserved by the deletion of all references that would allow identification of patients, secure storage of research media, and by access to session tapes being strictly limited. All therapists and patients in the study were offered debriefing sessions. Two therapists wished and were subsequently given written feedback about the outcome of the research; the peer reviewed publication on the pilot study (Beach and Power, 1996).

ii) Allocation of therapy tapes to treatment conditions

The study's intention was to research naturally occurring differences between the major psychological therapies. It was also intended that each therapy type was administered in the field by experienced and qualified therapists with recognised expertise in the therapy they specialised in. Therapists were therefore deliberately assigned to each condition on the basis of the therapy being undertaken e.g. as noted above, therapist A was a recognised expert in psychodynamic psychotherapy, only worked in this theoretical model, and was based in a National Health Service specialist treatment centre where only psychodynamic psychotherapy was available. Session transcriptions of his psychodynamic work at this centre were therefore allocated to the psychodynamic psychotherapy condition.

Thus selection and allocation of therapists to therapy conditions reflected the study's intention to research naturally occurring differences between psychological therapies as applied in skilled daily clinical practice. The National Health Service Research and Development Strategic Review (1999) has recently argued the need for such research, "under (the) usual service conditions of psychological and psycho-social interventions" (p.5), as a priority research area. Selection of therapists was on the basis of their recognised expertise and National Health Service specialism in their respective therapy models. Allocation of each therapist to a specific therapy condition was not randomised but deliberate on the basis of this expertise and specialism in that therapy. Chiesa and Fonagy (1999) argue for such selection and allocation not just in psychotherapy research of naturally occurring differences but also because of the increased generalisability of findings it potentially offers. In addition, they argue that the criteria required by randomised controlled trials of psychological therapies commonly limits external validity as the resultant strictly controlled therapy does not reflect or allow normal, responsive, clinical practice. Indeed, Henry, Strupp, Butler, Schacht and Binder (1993) have empirically demonstrated such change in the nature of the therapy being offered and its impact on various process and outcome factors, including a worsening in the patient-therapist alliance. Whilst researching naturally occurring differences between psychological therapies required deliberate assigning of specific therapists to specific conditions and whilst there were positive benefits pertaining to generalisability there was one main disadvantage. The small number of therapists in each condition left a greater possibility of individual therapist differences confounding or causing therapy differences. In the main study this issue is addressed further and the number of therapists in cognitive-behaviour and psychodynamic therapies increased.

A discussed in Chapter One, there are many theoretical and technical commonalties between therapies, and as Strupp (1983) has argued potentially more so in a study such as this which researches what clinicians do rather than what they say they do. However, each treatment condition was of a discrete therapy type delivered by specialist whose daily clinical practice was in that therapy and as noted above adherence to protocol checks of verbal-response mode usage of therapists (Hardy and Shapiro, 1985) provided evidence of this.

iii) Transcribing and rating the tapes of therapy sessions

Detailed verbatim transcriptions, including paralinguistics, were made of forty taped complete sessions drawn equally from the four therapy types: cognitive-behaviour, cognitive, conversational and psychodynamic and within each group equally from sessions early and late in treatment (see Appendix 6 for example transcription). Early sessions were drawn from the first five, but not the first session, and late sessions from the last five, but not the last session. All patient and all therapist statements in transcriptions were rated using the transference coding system. Each statement was rated separately i.e. without reference to previous statements, the exception to this being that it was permissible to look to the previous statement to clarify what was being referred to in the statement currently being rated. Each statement was also rated completely i.e. for all potential transference components, before moving on to the next statement. Rating codes were annotated in the transcription margin and then transferred to a coding sheet before entering into a computerised data matrix on SPSS Base Version 8.

2.5 Results

Results are presented first in which the main effect analysed was the type of therapy and which address the presence of transference referents across the range of therapies. These analyses pertain to references made, both explicitly and implicitly, to individual transference components, by patients and therapists. They also examine the linking of references to transference components within statements. In the second set of results presented the main effect analysed was session order, so that these analyses pertain to variations in references to transference components between sessions early in therapy and those late in therapy.

Data were analysed using SPSSPC Version 3.1.

2.5.1 The Presence of Transference References Across Therapies

i) Patient Statements - Individual Transference Components

The percentage of patient statements, across the four therapy groups, in which each of the 10 transference components were referred to are presented in Table 2.3.

Explicit References by Patients - There was a significant variation across therapies in the number of explicit references made by patients about parents ($F(3,36)=18.12$, $p<0.001$), therapists ($F(3,36)=21.34$, $p<0.001$) and past feelings ($F(3,36)=11.29$, $p<0.001$). Further analyses showed that more references were made in the short term psychodynamic psychotherapy group about each of these transference components than in the other groups (Scheffe test, $p<0.001$, $p<0.05$, $p<0.05$ respectively), which did not differ significantly from each other. There was also a significant variation across the therapy groups in references made to conflict ($F(3,36)=9.93$, $p<0.001$), with the short term psychodynamic psychotherapy group making more references (Scheffe test, $p<0.05$) than the cognitive and cognitive-behavioural therapy groups which did not differ significantly from each other or from the conversational therapy group. There was no overall significant effect of type of therapy on references to current feelings.

Table 2.3. Percentage of patient statements in which each of the 10 transference components were identified

Group Referent	Cognitive	Cog-Beh.	Conv.	Psychodynamic
Explicit reference to:				
Therapist	6.20	4.00	13.30	31.40
Parent	3.00	2.40	7.30	25.30
Current feeling	57.80	54.70	69.30	62.00
Past feeling	3.20	0.90	4.40	17.00
Conflict	5.90	9.30	14.30	24.30
Implicit reference to:				
Therapist	15.70	19.40	25.20	32.10
Parent	2.10	2.80	6.80	8.20
Current feeling	2.60	3.40	5.80	11.70
Past feeling	3.60	6.60	12.90	19.80
Conflict	5.00	5.80	7.70	17.40

Implicit References by Patients - There was a significant variation across therapies in the number of implicit references made by patients about the therapist ($F(3,36)=5.35$, $p<0.05$), past feelings ($F(3,36)=12.45$, $p<0.001$), current feelings ($F(3,36)=5.58$, $p<0.05$), parents ($F(3,36)=4.10$, $p<0.05$) and conflict ($F(3,36)=15.10$, $p<0.001$). Further analyses showed more references were

made about the therapist and about conflict (Scheffe test, $p<0.05$ and $p<0.001$ respectively) in the short term psychodynamic group than in other therapy groups, which did not differ significantly from each other. Patients in the psychodynamic groups (conversational and short term psychodynamic) made more references to current and past feelings (Scheffe test, $p<0.05$ and $p<0.001$ respectively) than did patients in the cognitive-behavioural groups (cognitive-behavioural and cognitive groups).

ii) Therapist Statements - Individual Transference Components

The percentage of therapist statements, across the four therapy groups, in which each of the 10 transference components were referred to are presented in Table 2.4.

Table 2.4. Percentage of therapist statements in which each of the 10 transference components were identified

Group Referent	Cognitive	Cog-Beh.	Conv.	Psychodynamic
Explicit reference to:				
Therapist	4.60	1.70	14.00	28.30
Parent	1.60	2.20	4.30	25.00
Current feeling	46.00	54.00	67.70	59.40
Past feeling	0.10	2.00	4.10	15.30
Conflict	3.40	3.70	7.60	12.60
Implicit reference to:				
Therapist	9.10	10.50	15.10	8.50
Parent	1.20	1.00	2.38	2.30
Current feeling	3.00	3.00	3.00	3.90
Past feeling	1.80	2.60	5.90	8.80
Conflict	2.90	3.10	7.40	15.90

Explicit Therapist References - There was a significant variation across therapies in the number of explicit references made by therapists about themselves ($F(3,36)=13.38$, $p<0.001$), parents ($F(3,36)=24.32$, $p<0.001$), past feelings ($F(3,36)=12.96$, $p<0.001$) and conflict ($F(3,36)=6.05$, $p<0.05$). Further analyses showed more references were made about therapists, parents and past feelings in the short term psychodynamic psychotherapy group than in other groups (Scheffe test, $p<0.001$, $p<0.001$ and $p<0.001$ respectively), which did not differ significantly from each other. The psychodynamic groups also contained more references to conflict than in the cognitive-

behavioural groups (Scheffe test, $p<0.05$). There was no significant effect of type of therapy on references to current feelings ($f=2.35$, n.s.).

Implicit Therapist References - There was a significant variation across therapies in the number of implicit references made by therapists about past feelings ($F(3,36)=5.69$, $p<0.05$) and conflict ($F(3,36)=13.12$, $p<0.001$). Further analyses showed more references were made about past feelings and conflict in the short term psychodynamic group than in the cognitive-behavioural groups (Scheffe test, $p<0.05$ and $p<0.05$ respectively) which did not differ significantly from each other.

Table 2.5. Correlations, combined across all therapies, of summated explicit, implicit, and combined explicit and implicit references to transference components (excluding and including conflict) in patient and therapist statements (Pearson r)

Variable	Explicit (E) or Implicit (I) including conflict	Combined Explicit and implicit excluding conflict	Combined Explicit and implicit including conflict
PETRANS	.9792++ (E)	.9616++	.9534++
PITRANS	.9910++ (I)	.9178++	.9115++
TETRANS	.9946++ (E)	.9726++	.9714++
TITRANS	.9015++ (I)	.6983++	.6776++

++p<0.001
PETRANS-summated patient explicit transference components excluding conflict
PITRANS-summated patient implicit transference components excluding conflict
TETRANS-summated therapist explicit transference components excluding conflict
TITRANS-summated therapist implicit transference components excluding conflict

iii) Patient and Therapist Statements - Summated Transference Components

The more transference components referred to in a statement the more clearly the statement would be transferential. The sum of the transference components in each patient and therapist statement were therefore calculated. Correlational analyses, presented in Table 2.5, showed all summated references, both including and excluding conflict, to be significantly correlated. Therefore only the mean number of transference components referred to in each patient and each therapist statement, excluding conflict, are given in Table 2.6.

There was a significant variation across therapies of the mean total of transference components referred to explicitly, implicitly and explicitly and implicitly combined in patients' statements ($F(3,36)=27.44$, $p<0.001$, $F(3,36)=13.30$, $p<0.001$ and $F(3,36)=13.30$, $p<0.001$) and explicitly and explicitly and implicitly combined in therapists' statements ($F(3,36)=20.17$, $p<0.001$ and $F(3, 36)=20.17$, $p<0.001$). Further analyses showed the short term psychodynamic psychotherapy group to have a significantly higher rating than the cognitive-behavioural therapies in all but therapists' implicit references (Scheffe test, $p<0.001$). Analysis of implicit therapist statements showed no two groups to be significantly different.

Table 2.6. The mean summated explicit and implicit references to transference components for each patient and therapist statement, excluding conflict

Group Variable	Cognitive	Cog-beh.	Conv.	Psychodynamic
Patient explicit	0.702	0.618	0.944	1.360
Patient implicit	0.321	0.243	0.508	0.691
Therapist explicit	0.552	0.575	0.904	1.276
Therapist implicit	0.161	0.171	0.283	0.226

Maximum possible mean summated score = 4.

2.5.2 Therapist Response to Patient Transference Statements

For each patient-therapist paired statement, the summated transference score of the therapist response was subtracted from the summated transference score of the patient. This indicated whether therapists' statements referred to more, less or the same number of transference components as the patient statements they were responding to. A score of '-4', for example, being obtained when the patient statement refers to no transference components and the therapist to four, and a score of '+4' when the patient statement refers to four transference components and the therapist none. To refer consistently to less may indicate a lack of therapist interest in, or awareness of, references made. To refer consistently to more may indicate therapist comments aimed at uncovering latent meaning in patient statements and making links with other experiences of the patient.

Table 2.7 presents a breakdown by percentage of the range of scores obtained, derived from explicit transference references excluding conflict. Correlational analyses showed significant correlations, ranging from $r=0.38$, $p<0.01$ to $r=0.94$, $p<0.001$, between these scores and other subtracted transference scores i.e. explicit scores including conflict and combined explicit and

implicit scores, both when conflict components were included and excluded, and whether the patient statement contained references to transference components or not.

The analysis of subtracted transference scores showed no overall significant effect of type of therapy ($F(3,36)=1.01$, n.s.). No groups had scores of '-4' or '+4' but the short term psychodynamic psychotherapy group had a higher percentage of scores of value '-3', '-2' and '+2' (Scheffe test, $p<0.05$, Scheffe test, $p<0.05$ and Scheffe test, $p<0.001$ respectively) than the other groups, which did not differ significantly from each other. The short term psychodynamic psychotherapy group also had a lower percentage of subtracted transference scores of value '0' (Scheffe test, $p<0.001$) than other groups, which did not differ significantly from each other. There was a significant effect of group in analysing therapists' response to patients' explicit ($F(3,36)=7.45$, $p<0.001$) and implicit ($F(3,36)=10.07$, $p<0.001$) references to them (see Table 2.8). Short term psychodynamic therapists made more transference references in response to such explicit (Scheffe test, $p<0.05$) and implicit (Scheffe test, $p<0.001$) references than therapists in other groups.

Table 2.7. Breakdown by percentage of subtracted transference scores of paired patient - therapist statements

Group Score	Cognitive	Cog.-beh.	Conv.	Psychodynamic
-4	-	-	-	-
-3	0.07	-	0.44	2.50
-2	1.47	0.91	4.30	8.50
-1	21.30	22.20	16.70	21.30
0	56.32	50.39	48.46	29.82
+1	24.07	23.02	20.26	23.12
+2	3.22	1.94	5.28	10.59
+3	0.27	0.29	0.40	2.72
+4	-	-	-	-
Mean Score	0.16	0.04	0.03	0.08

Table 2.8. Mean number of transference components in therapist explicit responses to patient references to the therapist

Group variables	Cognitive	Cog.-beh.	Conv.	Psychod.	Potential max. score
Explicit patient reference to therapist	0.59	0.63	1.14	1.36	4
Implicit patient reference to therapist	0.63	0.65	1.06	1.39	4

2.5.3 Comparison of Transference References across Early and Late Therapy Sessions

Early sessions were taken from the first five sessions of therapy and late sessions from the last five. Patients made more explicit references linking current and past feelings, parent and therapist in late compared with early sessions and this approached significance ($F(1,32)=3.57$, $p<0.068$). There was no significant effect of session order on the linking of patients' implicit references or therapist explicit and implicit references.

Inspection of data suggested that patients in all groups made more explicit transference references in late sessions of therapy than in early. The data also suggested that both patients and therapists in the psychodynamic psychotherapies made less implicit transference references in late sessions. Conversely patients in the cognitive-behavioural therapies appeared to make more such references in late sessions. There was no difference across sessions in the frequency of implicit transference references made by cognitive-behavioural therapists. These results are presented in Table 2.9.

Table 2.9. Mean summated references to transference components by group and session order

Group & session order	Pt. implicit	Pt. explicit	Th. explicit	Th. implicit
Cognitive				
Early	0.23	0.67	0.16	0.54
Late	0.25	0.73	0.16	0.56
Cognitive-beh.				
Early	0.31	0.58	0.17	0.54
Late	0.33	0.66	0.17	0.61
Conversational				
Early	0.53	0.91	0.31	0.90
Late	0.49	0.98	0.26	0.91
Psychodynamic				
Early	0.73	1.23	0.26	1.15
Late	0.65	1.49	0.20	1.40

2.6 Discussion

Although patients and therapists across all the therapies made references to transference components, these were significantly lower in cognitive-behavioural than in psychodynamic therapies. Patients in cognitive-behavioural therapies did make statements linking all transference components: the therapist, parent, past and current feelings and conflict. However these accounted for less than 1% of total statements in the cognitive therapy group and 2% of total statements in

the cognitive-behavioural group. Nonetheless, these findings countered the view of some analysts (e.g. Waelder, 1956) that transference is peculiar to the analytic encounter and provided some support for the view that it pervades all therapeutic relationships.

The higher ratings of transference components in psychodynamic therapies, particularly short term psychodynamic, provided support for the rationale presented by psychodynamic therapists for refraining from personal disclosure and providing limited opportunities for patients to reality test about the relationship. This it is argued facilitates a transferential relationship in which the patient enacts interpersonal styles in relation to the therapist that are derived from conflictual childhood relationships.

2.6.1 Patients' Transference References

It had been hypothesised that patients in cognitive-behavioural therapies would make fewer references explicitly to transference components because their therapists would attend less to such references than would psychodynamic therapists. This was shown to be so. In the case of patients' implicit references about therapists and therapy, inspection of data suggested that these were higher than their respective explicit references in cognitive, cognitive-behavioural and conversational therapies. This raises for consideration the possibility that explicit references about therapists were not facilitated in these groups, but sought expression nonetheless through implicit routes. It also raises for consideration the possibility that implicit references about therapy and the therapist are more frequent in psychological therapies than are usually acknowledged. If, as is likely, negative feelings about therapy are more usually expressed implicitly (cf. Gill and Hoffman, 1982), then early recognition of these may lessen the incidence of treatment noncompliance. On a more general note, patients in cognitive-behaviour therapies did not simply suppress explicit references to transference components and divert them all to implicit expression. If this had been so, then implicit references would have been higher in cognitive-behaviour therapiesthan psychodynamic, but they too were generally lower. This finding raised questions about the nature of repetition compulsion (Freud, 1920), the tendency of unresolved conflicts to repeat themselves. Doubt is cast on 'economic' instinctual explanations of the phenomenon which expect absolute instinctual discharge and thereby expression within therapy; the notion that the unconscious mind will express itself. Perhaps unresolved conflicts pushed out of consciousness actively seek re-expression through implicit references to transference components but need 'hooks' onto which to express themselves in the same way that, argued Freud (1900), dreams need residues of the day as the elements through which to express unconscious wishes to which they are

distantly connected. A facilitative environment may be required for the expression of implicit as well as explicit transference. The higher levels of implicit references to transference components in psychodynamic therapies may reflect this need and its being met by their particular working style with, for example, less agendaed sessions, less directive therapists and exploration of underlying meaning of behaviour, feelings and thoughts.

2.6.2 Therapists' Transference References

Short term psychodynamic therapists made a significantly higher number of references to transference components than did conversational therapists and both, as hypothesised, made a significantly higher number of references than did their counterparts in cognitive-behavioural therapies. Psychodynamic therapists also made a significantly higher percentage of explicit references about themselves than did cognitive-behavioural therapists, including in response to patients' explicit and implicit references about them. This provided support for the idea that a defining feature of psychodynamic therapies is exploration of the patient-therapist relationship.

Therapists in psychodynamic therapies responded more frequently and more fully to patient transference statements than therapists in the cognitive-behavioural therapies. There was no overall significant group effect in analyses based on therapists' mean summated transference scores subtracted from the scores of patient statements they were responding to. However, it is likely this reflects the high level of patient references to transference components in psychodynamic therapy.

Psychodynamic therapists, more often than cognitive-behavioural, responded to patients' statements with significantly more or significantly less transference components than were in the patient statement. This suggested transference references are not always immediately responded to in psychodynamic therapies, for which there may be a variety of reasons. Some psychoanalysts for example consider interpretations should only be made when transference increases, is negative, and impedes the progress of treatment (cf. Luborsky, Bachrach, Graff, Pulver and Critsoph, 1979): perhaps sound advice for cognitive-behavioural therapists. But the lack of an always immediate response is not suprising for another reason. In the consulting room contextual information such as previous utterances are important in construing the presence and nature of transference. This fact is true whether one is a Kleinian psychotherapist, for whom a single reference to a transference component may have transference implications, or a Freudian or Object Relations psychotherapist, who requires accumulated references to components to provide evidence of transference. In the pilot study, raters were denied access to contextual information such as previous statements in

order to test whether or not individual statements were sufficient for the coding of transference information.

2.6.3 Transference References Across Early and Late Therapy Sessions

In cognitive-behavioural therapies, as predicted, therapists responded much less to patients' explicit references to transference components than did psychodynamic psychotherapists. Despite this finding such patient references were more frequent in late than in early sessions. Patients' explicit references were also higher in late sessions of psychodynamic therapy. At first sight this may seem to reflect the importance placed in psychodynamic therapies (cf. Graff and Luborsky, 1977) on interpreting the latent meaning of patients' experiences thereby making implicit material explicit. However, support for there being a process in this group for the transfer of unconscious material to consciousness was not conclusive because although implicit transference did lessen, it did not do so significantly. Furthermore, implicit references are not unequivocally unconscious but may include conscious but not directly expressed material: for example, negative feelings toward the therapist that may be difficult to express directly. A reduction in implicit references could therefore reflect conscious but indirect material being expressed more openly, perhaps within the context of an improving therapeutic alliance.

2.6.4 Consideration of the Differences Found Between the Conversational Therapy Group and the Short Term Psychodynamic Therapy Group

When compared to the short term psychodynamic therapy group, therapists in the conversational therapy group made significantly less explicit references to all individual transference components, except to current feelings. They also made significantly less statements linking transference components. When compared to the cognitive-behavioural therapy groups, therapists in the conversational therapy group did make more references to individual transference components and more statements linking transference components. But with the exception of the linking of past and current feelings, therapist and parent, none of these differences reached significance. This finding is likely to be explained by the treatment focus of conversational therapy. In common with other psychodynamic therapies conversational therapy is based on the rationale that patients enact their problems within the patient-therapist relationship and that a mutative process occurs through exploration, understanding and re-adjustment of this relationship. But in contrast to the short term psychodynamic group the focus of therapy is on what is happening in the present, with references less frequently made to the therapist and parent than to present significant others. References to

past experiences are considered relevant only in so far as they promote a 'language of feeling' in the present.

2.6.5. Conclusions

The pilot study found support for the occurrence of references to transference components in both cognitive-behaviour and psychodynamic therapies. The frequency of these references, however, were markedly lower in cognitive-behavioural therapies, and psychodynamic therapies were considered the context *par excellence* of transference. Therapists in psychodynamic therapies, as hypothesised, made a higher number of transference statements and responded more fully to patient references about the therapist.

Compared to other references, patients in cognitive-behaviour therapies made a high number of implicit references about the therapist. It is suggested the cognitive-behaviour therapies that were analysed did not generally facilitate overt comment on the therapeutic relationship and therefore implicit comment was necessitated. Such inattention to interpersonal issues may potentially damage the therapeutic alliance and lead to treatment non-compliance or drop out. It was argued that cognitive-behaviour therapies would benefit from a theoretical framework within which to understand the 'intrusion' into treatment of resistance behaviour (e.g. Power, 1991). The exploration of such behaviour as it arises would also uncover aspects of patients' difficulties, not established during assessment, which may be ameliorated during treatment.

Patients' explicit transferences approached being significantly higher in late than in early sessions of cognitive-behaviour therapies. This suggested that transference is not extinguished if therapists do not acknowledge or recognise it. In the psychodynamic therapies this increase in explicit transference references was accompanied by a reduction in implicit references. Although this reduction did not achieve significance, it does provide some support for a process in psychodynamic therapies wherein the exploration, understanding and re-adjustment of the patient-therapist relationship facilitates the transfer of unconscious material (implicit transference) to consciousness (explicit transference) where there may be increased patient awareness and control of it. The level of transference in early sessions of therapy cast doubt on the view held by some therapists that transference is little present in early psychotherapy sessions.

In summary, the pilot study demonstrated the utility and reliability of the Transference Coding System in exploring and identifying differences across cognitive-behaviour and psychodynamic therapies in the references to transference components made by patients and therapists. The following chapter introduces a larger scale study which evolved from the pilot study and addressed

issues which arose within it. The study researched a larger number of therapies, therapy sessions, therapists and patients, explored the focus of therapists' interventions from a broader base, and analysed the level of transference references from a greater number of perspectives. In so doing it, for example, minimised the potential contamination of therapy differences by therapist differences and differences in narrative and session lengths. Given the significant differences found between the conversational and psychodynamic psychotherapy groups it also introduced a third psychodynamic psychotherapy, psychoanalytic psychotherapy. In addition, given the high level of implicit transference references found and that negative feelings are commonly expressed implicitly, the study also researched patients' negative thoughts and feelings about therapy and therapist response to it. It also explored the focus of therapist interventions from a broader base than from transference.

CHAPTER 3

THE MAIN STUDY

The pilot study demonstrated the occurrence of transference references in all the psychological therapies it researched. It also showed clear differences between cognitive-behavioural and psychodynamic psychotherapies in patients' references to transference components and therapists' response to this.

The present study builds on the pilot study's investigation of transference in the major psychological therapies. It is a larger scale study. First, it undertook similar areas of analyses as the pilot study but did so over a greater number of psychological therapies, treatment sessions, therapists and patients. Second, it undertook new areas of analyses, in particular investigating more broadly the focus of therapists' interventions and also patients' negative commentary about therapy and therapists, and how therapists' respond to this. Third, it addressed methodological shortcomings of the pilot study. These issues are expanded upon beneath.

3.1 The Occurrence of Transference References across Psychological Therapies

3.1.1 Issues raised by the pilot study

The Number of Therapists - Shapiro, Firth-Cozens and Stiles (1989), whose research group subsequently contributed to the pilot study's cognitive-behavioural and conversational therapy groups, indicated that the differential effectiveness of one therapy over the other could be contaminated by the differential effectiveness of therapists where there are very small numbers of therapists involved. That is, differences between the groups could reflect therapist variables rather than differences in the therapies themselves. Therefore, the present study increased the number of therapists in the cognitive-behavioural and psychodynamic groups.

The Range of Psychological Therapies - The cognitive-behavioural, cognitive, conversational and short term psychodynamic therapy groups of the pilot study are added to by other therapy

groups in the present study. In the pilot study the conversational therapy group tended to be significantly different from its fellow psychodynamic therapy on many measures, whilst not being significantly different from cognitive-behavioural therapies. The present study provides a third cognitive-behavioural therapy group, behavioural therapy, and a third psychodynamic therapy group, psychoanalytic psychotherapy; the latter to compare and contrast with the other two psychodynamic therapy groups, conversational and short term psychodynamic.

In addition to increasing the number of therapists and therapies in the present study more patients and more treatment sessions were analysed.

The Relationship between the Level of Explicit and Implicit Transference References - The pilot study did not reach clear conclusions about the relationship between the level of explicit and the level of implicit transference references. For example, patients in cognitive-behavioural therapies made a smaller number of explicit and a smaller number of implicit transference references than did their peers in psychodynamic psychotherapies. This cast doubt on classical psychoanalytic views of the necessity of the conflicts inherent in transference seeking expression, for example, Laplanche and Pontalis (1988) 'transference phenomena emerging during the treatment serve to confirm this necessity for the repressed conflict to be re-enacted in the relationship with the analyst' (p. 79). Such a view would suggest that low levels of explicitly expressed transference references would lead to a need for higher implicit references; this did not occur in the pilot study. Interestingly, however, inspection of data suggested that in all groups, apart from the psychodynamic psychotherapy group, patients' implicit references to the therapist were higher than their respective explicit references and higher than all other implicit references. This raises for consideration the tentative hypothesis that explicit references to the therapist were not required or facilitated in these groups, but sought expression nonetheless through implicit routes.

Despite the above tentative conclusion that prescriptive therapies did not facilitate patients' explicitly referring to the therapist and so this happened implicitly, the pilot study's more general hypothesis that explicit transference references would occur less in late sessions of cognitive-behavioural therapies than in early because they would not be attended to, was not supported. Explicit transference scores approached being significantly higher in late than in early sessions of cognitive-behavioural therapies and this did not appear to be simply due to implicit transference becoming explicit, because implicit transference did not significantly decrease.

The present study considered further the relationship between levels of explicit and implicit references, and did so across a wider range of therapies.

Comparison of Early and Late Sessions - The pilot study did not provide conclusive support for the view that resolution of transference is a primary mutative factor in psychodynamic therapy. This view, based on the transfer of unconscious material to consciousness, would have required a significant increase in explicit references to transference components in late over early sessions and a significant decrease in implicit references. Explicit transference references did indeed increase but fell a little short of significance and there was only a small decrease in implicit transference.

The present study re-examined this possible process in psychodynamic psychotherapy and also examined it within long term psychoanalytic psychotherapy.

Time Frame of Therapists' Interventions - Castonguay et al (1995) not unexpectedly found that cognitive-behavioural therapists worked more within current and future time frames and psychodynamic psychotherapists more within current and past time frames. Yet the pilot study did not find any significant difference between cognitive-behavioural and psychodynamic therapies in patients making links between past and present feelings. This finding, perhaps suprising when one considers that both cognitive-behavioural therapies in the pilot study expressed focusing not on the origins of patients' problems but on what maintains them, is reconsidered in the present study.

Transference Coding System - The Transference Coding System developed and utilised in the pilot study showed good inter-rater reliability and demonstrated its usefulness as an instrument which can look beneath the immediate content of patients' and therapists' utterances and reliably rate implicit content. However, inspection of the definitions conceptually analysed suggested that a significant minority were from classical psychoanalysis with an underepresentation of definitions from the independent group and psychodynamic psychotherapy. Therefore, the present study conceptually analysed a further group of transference definitions identified in a second literature research and compared the results of the two analyses.

Methodological - The majority of statistical analyses in the pilot study were based on percentages of patient and therapist statements containing references to each of the various transference components. The present study undertook such analyses too. But it also undertook analyses based on the mean number of references to the various components per patient or therapist statement and per line of patient or therapist narrative. This controlled for the possibility that differences or

degree of significance of differences between groups, or the failure to find differences arose from a confounding variable of session length or statement length. Thus, by way of example, in the pilot study the number of references to transference components in the psychodynamic group was significantly higher than in the other groups. However if these frequencies were taken as a function of session (word) length, then the degree of significance would be higher still due to the relatively low word count of psychodynamic psychotherapy session transcriptions.

3.1.2 Conceptual Analysis of Transference II

As noted above the first conceptual analysis contained a potential over-representation of transference definitions from classical psychoanalysis and an underepresentation from the independent group and psychodynamic psychotherapy. A second conceptual analysis was therefore undertaken which allowed assessment of the reliability and validity of the first analysis. The second literature search, as previously (see page 19), used PsycLIT and the British Association of Psychotherapists library. It also used the medical library of a major London teaching hospital, St George's, which contained a smaller number but a greater theoretical breadth of psychotherapy texts. In addition to the original 44 definitions a further 21 definitions were identified and these are listed in full in Appendix 4. A conceptual analysis of this second group of definitions (see Tables 3.1 and 3.2) identified the same 'primitives' as the original conceptual analysis:

i) Conflict - derived from conflict, intrapersonal or interpersonal
ii) Inappropriate - not fully appropriate to the present
iii) Past - derived from past experience
iv) Parent - derived from the relationship with parents
v) Therapist - refers to the therapist/therapy
vi) Lack of awareness - patients lack of awareness of their transference
vii) Attitude - the transfer of attitudes
viii) Behaviour - the transfer of behaviour
ix) Feeling - the transfer of feelings
x) Thoughts/Ideas/Memories - the transfer of thoughts, ideas or memories
xi) Wishes/Impulses - the transfer of wishes or impulses
xii) Fantasy/Phantasy - the transfer of fantasies or phantasies

Table 3.1. Conceptual Analysis of Transference Definitions - Part One

	Conflict	Inapprop.	Past	Parent	Therap.	Lack of awareness
Baron (1987)		*	*	*	*	
Belki (1980)			*	*	*	
Bloch (1982)		*	*	*	*	
Brown & Pedder (1979)		*	*		*	
Brown & Pedder (1979)		*	*			*
Cramer (1992)				*	*	
Dolto (1974)		*	*		*	*
Freud (1910)	*	*	*		*	*
Hildebrand (1983)		*	*		*	*
Holmes & Lindley (1989)	*	*	*	*	*	*
Klein (1952)	*		*		*	
Lagache (1953)			*	*	*	*
Lomas (1981)		*	*			
Menninger & Holzman (1973)		*	*		*	*
Rosen (1986)	*				*	
Sainsbury (1974)			*	*	*	*
Weiner (1976)		*	*		*	
Wolf (1988)	*		*		*	
Wolf (1988)	*	*	*			
Wolff (1983)		*	*		*	*
Wolff, Bateman & Sturgeon (1991)	*		*	*	*	

Table 3.2. Conceptual Analysis of Transference Definitions - Part two

	Attitude	Behav.	Feeling	Memory/ thought	Wish/ impulse	Fantasy/ phantasy
Baron (1987)			*	*		
Belki (1980)			*			
Bloch (1982)	*		*			
Brown & Pedder (1979)	*		*			
Brown & Pedder (1979)		*	*	*		
Cramer (1992)			*			
Dolto (1974)			*		*	
Freud (1910)			*		*	*
Hildebrand (1983)	*		*	*		
Holmes & Lindley (1989)		*	*		*	
Klein (1952)		*	*			
Lagache (1953)	*		*			
Lomas (1981)	*					
Menninger & Holzman (1973)	*					
Rosen (1986)						*
Sainsbury (1974)			*	*	*	
Weiner (1976)	*		*			
Wolf (1988)			*			*
Wolf (1988)			*			
Wolff (1983)			*	*		
Wolff, Bateman & Sturgeon (1991)			*			

As well as the same 'primitives' being identified in the second conceptual analysis as in the first, there was also little difference across the two analyses in the frequency with which most primitives were referred to. This was indicative of the reliability of the analysis and its concurrent and content validity. The frequency of 'primitives' identified in the first and second conceptual analyses of transference definitions are identified in Table 3.3 and discussed beneath.

The second conceptual analysis suggested, as did the first, that transference was derived from childhood relationships with significant figures. A significant minority of definitions identified the conflictual nature of these relationships. Whilst the therapist was identified as the recipient of transference others were not excluded as potential recipients. Approximately half the definitions identified transference as not being wholly appropriate and that patients were not fully aware of it. The overiding majority of definitions identified feelings as being transferred. Also identified as transferred were attitudes, behaviour, fantasies, ideas, impulses, memories, thoughts and wishes.

Though there was little difference in the frequency of most 'primitives' across the two analyses the second analysis showed a higher percentage of references to the transfer of feelings and a correspondingly lower percentage of references to the transfer of thoughts/ ideas/ memories and fantasies. It also showed a higher percentage of definitions referring to transference as being derived from parental figures. However this difference disappears if in the first analysis definitions are included in which references to parents and significant others from early/infantile life are clearly implied. For example, Freud (1920):

> These reproductions which emerge with such unwished for exactitude, always have as their subject some portion of infantile sexual life, of the Oedipus Complex, that is and its derivatives and they are invariably acted out in the sphere of the transference and of the patient's relation to the physician (p.288).

Or Freud, A (1947):

> By transference we mean all those impulses experienced by the patient in his relation with the analyst .... but have their source in early - indeed the very earliest object relations (p.18).

In this case, the percentage of the first set of definitions referring to parents rises from 14% to 31% and of definitions referring to past significant others from early/infantile life from 11% to 18%. Applying the same criteria to the second set of definitions sees their respective references remaining the same at 29% and 19%; thus 49% of the first set of definitions may be seen to refer to parents compared with 48% of definitions in the second set.

Inspection of the two sets of definitions showed the second to consist of more recent definitions overall (mean year 1976, median year 1981) than the first (mean year 1952, median year 1966). The second set of definitions also showed a much higher representation of psychoanalysts from the independent group and from self psychology, and from general commentators and psychotherapists (as opposed to psychoanalysts). The first set of definitions contained far more from classical psychoanalysts including a significant minority, 30%, from Freud. These differences may well explain the higher number of references to thoughts/ ideas/ memories and to fantasies in the first conceptual analysis. In classical psychoanalytic meta-psychology they and the instincts from which they are derived take a central position in a way the do not in the independent group, self psychology and psychoanalytic psychotherapy.

Summary of the Conceptual Analysis of Transference Definitions

Conflict - a conflictual origin to transference, intrapersonal or interpersonal, was referred to in 39% of definitions in the first conceptual analysis and 33% of definitions in the second conceptual analysis. References to concepts such as 'unconscious' and 'repressed' were taken to imply a conflictual basis.

Inappropriateness - Fifty-two per cent of definitions in both the first and second conceptual analysis indicated that the transference was not fully appropriate.

Derived From the Past - Transference was seen to be rooted in the past in 91% of definitions in the first conceptual analysis and in 90% of definitions in the second conceptual analysis.

Derived From Relationship with Parents - Fourteen per cent of definitions in the first conceptual analysis compared with 29% in the second explicitly referred to transference being derived from relationships with parents. Another 11% of definitions in the first analysis and 19% in the second analysis referred to relationships with significant childhood figures.

Refers to Therapist - Eighty per cent of definitions in the first conceptual analysis and 86% in the second referred to transference occurring toward the therapist.

Lack of Awareness - A lack of awareness, by the patient, of transference was stated by 52% of definitions in the first conceptual analysis and by 43% of definitions in the second analysis.

What is Transferred - Thirty per cent of definitions in the first analysis compared with 29% in the second referred to the transfer of earlier *attitudes* to the present and 20% in the first analysis

referred to the transfer of *behaviour* compared with 19% in the second. The transfer of *feelings* was identified in 50% of transference definitions in the first conceptual analysis compared with 86% of definitions in the second and 48% of definitions in the first analysis referred to the transfer of *thoughts/ideas/memories* compared with 24% in the second. Lastly 18% of definitions in the first analysis and 19% in the second referred to *wishes/impulses* and 20% in the first analysis and 14% in the second referred to the transfer of *fantasies (or phantasies).*

As with the original conceptual analysis, in this new analysis no definitions referred directly to transference being instinctually derived. Freudians and Kleinians however consider instinctual derivation to be implicit in terms such as wishes, phantasies and repetition compulsion, which were referred to.

Table 3.3. Summary of the Conceptual Analyses of Transference

'Primitives'	Percentage of sample I	Percentage of sample II
Conflict	39	33
Inappropriateness	52	52
Past	91	90
Parent	14	29
Past significant other	11	19
Therapist	80	86
Lack of awareness	52	43
Attitude	30	29
Behaviour	20	19
Feeling	50	86
Thought/idea/memory	48	24
Wish/impulse	18	19
Fantasy/phantasy	20	14

3.2 The Focus of Therapists' Interventions

The present study also examined the focus of therapist interventions across a broader base than in the pilot study. Given research (Kerr et al, 1992) showing in exploratory therapies a positive correlation between exploration of the patient-therapist relationship and treatment outcome, but in prescriptive therapies a negative correlation, further consideration will be given to how different therapies focus on the patient-therapist relationship. The present study also examined some therapy interfering behaviours expressed within the patient-therapist relationship including whether and

how therapists respond to negative patient material. More generally the research also examined the interpersonal and intrapersonal foci of therapists across psychological therapies.

Why study the focus of therapists' interventions ? Wolfe and Goldfried (1988) recommended that researchers measure important characteristics of pure forms of therapy as a step to elucidating the common and unique mechanisms of the different therapies. Therapist feedback is a central part to all psychological therapies and is a major mutative factor. Through it, patients gain insight into their behaviour, cognitions and feelings.

Compared with much previous psychotherapy research, the present study examines the focus of therapists' interventions across a wider range of psychotherapies, within actual therapy sessions of patients treated by therapists fully trained in and committed to the therapy they offered. In so doing, it also examined therapists' interventions more widely than in the pilot study, which analysed therapists' references to transference components. The present study considers:

3.2.1 Who therapists focus on

In Chapter One, previous research (e.g. Goldsamt et al,1992, Castonguay et al, 1995) was discussed which suggested the focus of cognitive therapy to be intrapersonal and the focus of psychodynamic therapy to be interpersonal. However, the pilot study showed that all therapies researched made references to interpersonal relationships. Looking at a specific interpersonal relationship, that between patient and therapist, the pilot study also showed that significantly more references to this relationship were made in psychodynamic psychotherapy than in the other researched therapies. This was in line with research also discussed in Chapter One which suggested that psychodynamic therapists focus more than cognitive-behavioural therapists on not just patients' therapists but their parents and the impact the patient has on others. When cognitive-behavioural therapists do focus on interpersonal issues, it is suggested they consider more the impact others have on the patient rather than vice-versa.

3.2.2 What therapists focus on

The view that cognitive-behavioural therapies are intrapersonal and psychodynamic therapies interpersonal in focus was questioned in Chapter One. Classical psychoanalysis for example has an emphasis upon the interaction between various components of the patient's internal world (cf. Prochaska, 1979) and Kerr et al (1992) found that cognitive-behavioural therapists made less interpersonal references than did psychodynamic therapists but still more than intrapersonal

references. The present study will analyse intrapersonal and interpersonal links and their respective proportion made across a much larger number of therapies, sessions, therapists and patients than in previous research.

3.2.3 What time frame therapists focus on

Previous research suggests that cognitive-behavioural therapists focus more within current and future time frames and psychodynamic psychotherapists more within current and past time frames. This will be investigated in the present study.

3.2.4 The link between therapist focus and outcome

Previous research (e.g. Kerr et al, 1992) has also suggested that an interpersonal focus is correlated with a good outcome in psychodynamic psychotherapy but a poor outcome in cognitive-behavioural therapy. Similarly, and more specifically, references to the patient-therapist relationship and outcome have been positively correlated in psychodynamic therapy (Shapiro, personal communication, Kernberg, 1973, Malan, 1976) and negatively correlated in cognitive-behavioural therapy (Shapiro, personal communication, Hayes et al, 1996).

Why this differential effect across therapies of focusing on the patient-therapist relationship ? In Chapter One it was noted that such references in psychodynamic therapy occur in a discursive context of how past experiences influence patients current relational patterns, including with the therapist. In contrast the focus of cognitive-behavioural therapy is typically within a current and future time frame. Interestingly Hayes et al (1996) found positive change in cognitive-behavioural therapy linked to exploration of early experiences to uncover core assumptions.

Perhaps more interestingly Castonguay et al (1996) found in the cognitive-behavioural therapy they researched that a focus on intrapersonal factors was positively correlated to depressive symptoms post therapy! Their regression analyses suggested this resulted from difficulties in the working alliance which therapists dealt with by challenging as examples of patients distorted thinking or by asserting the validity of cognitive-behavioural therapy. Both strategies led to escalating therapist pushing and patient disenchantment. Castonguay et al suggest therapists might better have facilitated the exploration of patients feelings. The present study will consider what happens when there is a strain in the working alliance in therapy sessions and how therapists respond to negative patient material both explicit and implicit.

3.3 Summary of the Aims of the Study

Drawing on the Pilot Study and on discussion in the Introduction a series of hypotheses were made which are detailed fully in the pertinent results sections. These hypotheses are summarised beneath:

3.3.1 References to Individual Transference Components

Patient References

Explicit and implicit patient references to transference components will occur in all therapies. These references (except to current feelings) will occur more in the Psychodynamic grouping of psychotherapies (conversational, psychodynamic and psychoanalytic) than in the Cognitive-behaviour grouping (behavioural, cognitive-behavioural and cognitive) and more in the Psychoanalytic and Psychodynamic psychotherapy groups than in other groups. Implicit patient references to the therapist and to conflict will be higher than their respective explicit references in the Cognitive-behaviour grouping of therapies.

Therapist References

Explicit and implicit therapist references to transference components will occur in all therapies. Explicit references (except to current feelings) will occur more in the Psychodynamic grouping of psychotherapies than in the Cognitive-behaviour grouping. Explicit references to the therapist and to conflict will occur more in the Psychoanalytic and Psychodynamic psychotherapy groups than in other groups. Explicit references to parents and to past feelings will occur more in the Psychodynamic psychotherapy group than in the three cognitive-behaviour therapy groups.

3.3.2 Summated and Linked Transference References

The Psychodynamic grouping of therapies will have a higher total of different transference components referred to per patient and per therapist statement than the Cognitive-behaviour grouping, and the Psychoanalytic and Psychodynamic psychotherapy groups a higher total than the three cognitive-behaviour therapy groups. These higher totals will occur across explicit, implicit and combined explicit and implicit references.

The Psychodynamic grouping of therapies will contain more linking of transference components than the Cognitive-behaviour grouping.

The Psychodynamic psychotherapy group will contain a higher number of patient and therapist statements than other groups making links which include references to parents and/or to past feeling and the Psychoanalytic psychotherapy group will contain a higher number making links which include combinations of references to current feeling, to therapist, and to conflict.

3.3.3 References to Transference Components Compared Across Early and Late Therapy Sessions

Patients' explicit references to transference components will be higher in late than in early sessions of all therapy groups. They will increase more, and be higher in late sessions, in Psychodynamic therapies than Cognitive-behaviour. Implicit references will decrease, and be lower in late sessions, in Psychodynamic psychotherapies than in Cognitive-behaviour therapies in which they will increase.

Therapists' explicit references to themselves will be high from the beginning of Psychoanalytic psychotherapy but will increase in late over early sessions of Psychodynamic psychotherapy.

Patients' and therapists' linking of combinations of explicit references to the therapist, to current feeling and to conflict will increase in late over early sessions of the Psychodynamic grouping of therapies and decrease in the Cognitive-behaviour grouping.

3.3.4 The Focus of Therapists' Interventions

What Therapists' Focus on

The Psychodynamic grouping of therapies will contain a higher number of references to emotions, interpersonal links and the patients' impact on others than will the Cognitive-behaviour grouping.

The Cognitive-behaviour grouping of therapies will contain a higher number of references to thoughts, behaviour and the impact of others on the patient, and offer more support, general information and self disclosure than the Psychodynamic grouping.

The Psychoanalytic psychotherapy group will contain more references to emotions and less references to thoughts than the Psychodynamic psychotherapy group.

Who Therapists Focus On

Therapists in the Psychodynamic grouping of therapies will make a higher number of references to themselves, parents and dream or fantasy figures, and make more links between person categories than therapists in the Cognitive-behaviour grouping.

Therapists in the Psychodynamic psychotherapy group will make more references to parents and less references to dream or fantasy figures than therapists in the Psychoanalytic psychotherapy group.

The Time Frames that Therapists Focus On

Therapists in the Psychodynamic grouping of therapies will focus more on childhood and in-session time frames and less on a future time frame, and make more links between time frames, than therapists in the Cognitive-behaviour grouping.

Therapists in the Psychoanalytic psychotherapy group will work more on an in-session time frame and less on on childhood than therapists in the Psychodynamic psychotherapy group.

3.3.5 Therapists' Response to Patients' Negative Material

Patient Negative Material

There will be no difference between the Cognitive-behaviour and Psychodynamic grouping of therapies in the level of patients' explicit negative material but the Cognitive-behaviour grouping will have a higher level of patient implicit negative material.

Therapist Response to Patient Negative Material

The Psychodynamic grouping of therapies will have a higher level of therapist facilitative responses to patient explicit and implicit negative material than will the Cognitive-behaviour grouping.

The Cognitive-behaviour grouping of therapies will have a higher rate of therapist restrictive responses to patient explicit and implicit negative material than will the Psychodynamic grouping.

The Psychodynamic grouping of therapies will have a higher, facilitative, mean therapist response rating than the Cognitive-behaviour grouping's lower, restrictive, mean rating.

CHAPTER 4

METHOD

4.1 Approval

An application for approval of the research was made to the Ethical Committee of the Institute of Psychiatry, London (Appendix 1) and formal agreement received from the Secretary of the Committee (Appendix 2). The PhD was originally registered with the University of London but subsequently transferred to the University of Edinburgh.

The nature of the research was explained to all therapists in the study and their willingness to participate obtained. All tapes used involved patients who had given their consent for recordings of their treatment to be used for research purposes.

Steps were taken to preserve the confidentiality of information used in the research. These steps involved the deletion of all references that would permit the identification of patients, secure storage of research media, and access to session tapes and transcriptions being strictly limited to the research team.

All therapists in the study were offered debriefing sessions.

4.2 Participants

Eight therapists participated in the study, seven of whom were experienced Clinical Psychologists, the eighth being an experienced Clinical Nurse Specialist in behaviour therapy. All had recognised training and expertise in the respective psychological therapies they offered in the study.

The pilot study demonstrated that its methodology, including the Transference Coding System, was reliable and valid, and a paper of the study was peer reviewed and published (Beach and Power, 1996). In the absence of significant problems with the methodology, as briefly trialed in the pilot study, a similar methodology was used in this main study. This included researching

again, but more thoroughly and more fully, the naturally occurring clinical work of therapists, each of whom was a qualified specialist in a therapy being researched, and who worked in a National Health Service centre of excellence in that therapy.

Therapists A, B, C, D and E who had previously participated in the pilot study, and whose details are given in Chapter 2 (see page 45) were therefore utilised again as recognised experts in the therapies they offered. It should be noted however that the unit of analysis in this study, as in the pilot study, was the patient-therapist pair rather than the specific therapist or specific patient. New transcriptions and ratings of these transcriptions were used in this main study. Thus the units of analysis and the data were completely new and different from the pilot study.

Therapist F, a Senior Clinical Psychologist, had received substantial training in behaviour therapy as a psychologist and had five years post qualification experience in using it to treat adult patients in the National Health Service. She worked in a specialist behaviour therapy clinic in a centre of excellence renowned for its clinical work, research and training in behaviour therapy. Her clinical work was supervised by a Professor of Psychiatry with an international reputation for his expertise in this area.

Therapist G, a Behavioural Nurse Therapist, had undertaken a post qualification training in behaviour therapy at the Maudsley Hospital, London; the leading training centre in this country of specialists in behaviour therapy. This training had included teaching and reading on behaviour therapy and supervised clinical practice. She had six years post qualification experience of treating National Health Service patients with behaviour therapy. She too worked in a specialist behaviour therapy clinic in a centre of excellence renowned for its clinical work, research and training in behaviour therapy and was supervised by a Professor of Psychiatry with an international reputation for his expertise in this area.

Therapist H was as a Consultant Clinical Psychologist and qualified Psychoanalytic Psychotherapist with 14 years experience in the National Health Service of undertaking psychoanalytic psychotherapy with adults. His specialist psychotherapy training with the British Association of Psychotherapists, one of the country's leading training bodies, had included teaching and reading on psychoanalysis, supervised clinical practice and a personal training analysis. He was accredited by the British Confederation of Psychotherapists, the most stringent of the psychoanalytic psychotherapy regulatory bodies and was in supervision with a psychoanalyst from the Institute of Psychoanalysis, London.

Audiotaped and videotaped sessions of 23 patients in NHS treatment were utilised. Demographic and diagnostic data on these participants were not sought. All were adults who appeared to be suffering from anxiety and/or depression.

4.3 Design

The research utilised, as in the pilot study, both a between subjects and within subjects design.

There was one between subjects factor, the type of therapy of which there were six levels and one within subjects factor, session order, for which there were two levels, early or late in therapy. The six levels of the type of therapy were: Group 1 - Behaviour therapy, Group 2 - Cognitive-behaviour therapy, Group 3 - Cognitive therapy, Group 4 - Conversational therapy, Group 5 - Psychodynamic psychotherapy and Group 6 - Psychoanalytic psychotherapy. If the therapies are considered separately, then Group 1 consisted of therapists F and G and six sessions of one patient, four of another and two of another; Group 2 of therapists C and D and two sessions of each of five patients; Group 3 of therapist B and two sessions of each of three patients and four sessions of one patient; Group 4 of therapists C and E and two sessions of each of five patients; Group 5 of therapist A with 12 sessions of one patient, 11 of another patient, 6 of another and 2 of another; and Group 6 with therapist H with eight sessions of one patient and seven sessions of another patient. The sessions analysed in each of the six therapy groups were taken from sessions early and late in therapy. The interventions in Groups 1 to 5 were of between 10 and 16 sessions, and in Group 6 of between 200 and 300 sessions.

4.4 The Therapies

The six psychological therapies included in this study included four types of therapy that were in the pilot study; two cognitive-behavioural therapies: cognitive therapy and cognitive-behavioural therapy, and two psychodynamic therapies: conversational psychotherapy and short term psychodynamic psychotherapy:

Group 2: Cognitive-Behavioural Therapy

This method (see Shapiro and Firth, 1987) focuses on patient behaviour, thoughts and feelings outside of sessions and the provision by the therapist of self-management strategies for application by the patient (see page 45).

Group 3: Cognitive Therapy

This method (see Beck et al., 1979) views psychological difficulties as commonly resulting from habitual, dysfunctional, cognitions. Therapy aims to restructure these habitual errors in thinking, primarily by focusing on the here and now and on how problems are maintained, and rather less on the origin of these problems (see page 45).

Group 4: Conversational Therapy

This method (see Hobson,1985) views patients' problems as arising from disturbances in significant relationships. It aims to use the patient-therapist relationship to reveal, explore and diagnose problems and to learn new ways of dealing with them (see page 46).

Group 5: Short Term Psychodynamic Psychotherapy

This method (see Malan, 1976) considers unconscious conflicts to underlie patients' problems. The core of these conflicts is brought into consciousness through exploration of its re-enactment in the patient-therapist relationship. The therapist's facilitating of insight into the nature and origin of the core conflict is considered to help the patient resolve the conflict (see page 46).

The study also included two psychological therapies not included in the pilot study; one cognitive-behavioural: behaviour therapy, and one psychodynamic: psychoanalytic psychotherapy.

Group 1: Behaviour Therapy

This method (see Wolpe, 1958 and Rimm and Cunningham, 1985) views patients' difficulties as maladaptive forms of responding acquired through traumatic or inappropriate conditioning experiences i.e. they are learnt behaviour which can be unlearnt. The focus of therapy is upon patients' observable and measurable current behaviour as opposed to their thoughts and feelings. 'Insight' is not considered necessary for change to occur, though, it may facilitate the learning process. Behaviour therapists aim to ameliorate patients difficulties by developing with them treatment programmes which involve setting structured practical assignments and/or offering strategies to them for application outside of sessions. These programmes make use of techniques such as systematic desensitisation or covert sensitisation which are derived from classical (Pavlovian) or operant (Skinnerian) conditioning.

Group 6: Psychoanalytic Psychotherapy

This method (see Meissner, 1991) is a process which aims to reduce a patient's problems by facilitating the exploration of the underlying, sometimes unconscious, causes of their difficulties.

Through this exploration, in the absence of overt reassurance, instruction or advice, patients gain increasing insight into their internal world and its influence over present and past experience. This insight and the reparative nature of the therapeutic relationship may in turn lead to the resolution of their problems. The main focus of the therapy is the exploration of the patient's relationship with the therapist. This in turn is linked thematically with other aspects of the patient's current life and difficulties, and with past circumstances, through interpretation including of the patient's conflictual internal world. In common with the other psychodynamic therapies researched, psychoanalytic psychotherapy makes use not only of objective data but also of the subjective data that comes from the therapist's examination of their countertransference so as to vicariously introspect the patient's internal world. In contrast with the other psychodynamic psychotherapies also included in the research whose sessions are on a weekly basis, psychoanalytic psychotherapy sessions are a minimum of three times weekly.

4.5 Measures

4.5.1 The Transference Coding System

The present study utilised *The Transference Coding System* developed by the author as part of the research and which is described in Chapter Two (see page 39) and which demonstrated good reliability (see pages 42-43) (cf. Beach and Power, 1996).

4.5.2 The Coding System of Therapeutic Focus

The focus of therapists' interventions was coded using the *Coding System of Therapeutic Focus* (Goldfried, Newman and Hayes, 1989a, 1989b). The system was specifically developed to code the content of therapists' focus from transcriptions of both cognitive-behavioural therapies and psychodynamic psychotherapies, and to "provide a common language that could be used in conducting comparative process analyses across orientations" (Castonguay et al, 1995, pp.490-491). Its authors generated the items contained in the coding system from examination of therapy transcriptions. They then refined the system by a process of consulting leading researchers and clinicians from the cognitive-behavioural and psychodynamic fields to ensure that these items captured the important constructs of change, and by preliminary scoring of therapy transcriptions.

The *Coding System of Therapeutic Focus* consists of six main sections. The first section, *general interventions,* pertains to therapist feedback that focuses on broad aspects of patients' functioning such as facilitating patients to see that their perceptions may not accurately reflect reality. The

second section concerns the main *components of patient functioning* focused on by therapists such as action, emotion or thought. The third section, *intrapersonal links,* is concerned with connections made by therapists between different components of patients functioning, such as a patient's particular feeling arising from a thought they had. The fourth section, *interpersonal links,* refers to connections made between an aspect of a patient's functioning and an aspect of another person's functioning. This may capture the impact the patient makes on someone else, or the impact of another person on the patient. The fifth section, *context,* codes the context in which therapist feedback is given by way of its *time frame* and the *persons involved.* The sixth and final section, *person links and time links,* highlights parallels in a patient's functioning between the different times and different people in their life.

The unit of coding is the therapist turn, that is, everything said by the therapist after one patient utterance and before the next. The patient utterances before and after the therapist turn being coded can be used to provide contextual cues but are not themselves scored. Each coding item is coded as being present or absent within a therapist turn. Goldfried et al (1989a, 1989b) provide detailed guidelines for coding each of the system's items.

A total of three of the coding system's 51 items were omitted in the present study because they had not reached acceptable levels of interrater reliability (i.e. intraclass correlation coefficients of .60 or less) in previous studies (Goldsamt et al., 1992; Kerr et al., 1992). In the *components of patient functioning* section two items were omitted: *physiological signs of emotions* (physical manifestations of patients' emotions e.g shaking, blushing) and *unspecified* (patient's' functioning where no specific components have been identified). An item was also omitted from the *general interventions* section: *choices/decisions* (which pointed to patients' options, choices or decisions). All other items had demonstrated high levels of interrater reliability (Goldsamt et al., 1992).

Descriptions of items used from the *Coding System of Therapeutic Focus* are presented in Table 4.1.

Table 4.1. Description of coded items in the Coding System of Therapeutic Focus

Coding Item	Description
	General Interventions
Reality/unreality	Helping patient to step outside of their subjective perception and view things more objectively
Expected/imagined reaction of other	Exploration of patient's' subjective view of another person's reaction
Instance/significant theme	Indicating that a patient's functioning is part of a trend or pattern in her/his life
Therapist support	Therapist gives patient encouragement
Information giving	Providing general facts and knowledge that have therapeutic implications for patient
Changes	Referring to a change in the patient that is associated with therapy
Avoidances	Focusing on something the patient is doing that interferes with the process or progress of therapy
Self-Disclosure	Therapist shares with patient a personal experience relevant to patient's situation
	Components of Patient Functioning
Situation	Circumstances external to patient that are relevant to understanding her/his functioning
Self-observation	Patient's awareness and/or objective perception of self
Self-evaluation	Patient's evaluation of self
Expectations	Patient's anticipation about the future
Thought	Patient's thinking e.g general beliefs, appraisal of self worth
Intention	Patient's future-oriented volition, such as wish, desire, motivation, or need
Emotion	Patient's feeling

Action	Patient's behaviour
	Intrapersonal Links
Similarity/Patterns	Similarities or patterns within the patient's functioning
Difference/Incongruity	Divergences within patient's functioning
Vicious Cycle	A problematic aspect of the patient's functioning leads to another, which then leads to the original aspect
Consequences	One aspect of patient functioning has an effect on another aspect
	Interpersonal Links
Patterns	A component of patient's interpersonal functioning is repeated across time or setting or with different people
Vicious Cycle	Patient's interpersonal functioning exacerbates a problematic aspect of another's functioning, which in turn feedbacks adversely into the patient's original problematic functioning
Consequence	Patient's functioning is impacting on another person's functioning, or vice-versa
Compare/Contrast	Therapist compares or contrasts patient's functioning with that of another person
General Interaction	An interchange between the patient's functioning and the functioning of another person
	Context
Time Frame	Temporal focus of therapist feedback e.g within present session, infancy through secondary school
Persons Involved	On whom the therapist is focusing e.g. patient, therapist, parent, child

Person Links and Time Links

Time Links	Highlighting continuity or discontinuity in patient functioning over time
Person Links	Drawing links between persons in patient's life or disabusing the patient's erroneous perception of such links

4.5.3 The Therapist Response (Facilitative-Restrictive) Rating Scale

In addition to the transference and therapeutic focus coding systems, the present study also considered how therapists respond to patients' explicitly and implicitly expressed negative material. Transcriptions of therapy sessions spanning the major psychological therapies were reviewed to identify the type and range of potential implicit and explicit negative comments patients made about their therapy or therapist, and therapists' potential responses to these comments. The transcriptions reviewed included both ones from those in the study and from others not included.

From this review guidelines are provided beneath as to what is meant by implicit and explicit negative patient material and categories of therapist response to it are identified. A system for rating therapists responses, presented in Table 4.2, was drawn up specifically for this study. A preliminary investigation took one verbatim session transcription from each of the behavioural, cognitive-behavioural, cognitive, conversational, psychodynamic and psychoanalytic therapy groups. None of the transcriptions were of sessions included in the present study. All six sessions were then rated by the author and also by two independent raters, a clinical nurse specialist who was qualified as a psychotherapist and a Consultant Clinical Psychologist who was an experienced psychoanalytic psychotherapist. Both independent raters had received introductory training in the use of the rating scale and which included conjoint trial ratings with the author. The preliminary investigation demonstrated guidelines appropriately embraced the negative material patients may produce and that all therapist responses could be appropriately placed within the categories provided by the rating scale.

i) What is Implicit and Explicit Negative Patient Material ?

The negative patient material to be considered :

a) is negative in content: e.g. rage, anger, irritation

hostility, mistrust, destructiveness, sadism,
devaluation, criticism, disappointment, dissent
hostility, punishing, withdrawal, opposition, provocation

b) about the therapist or therapy

c) may be explicitly stated or implicitly stated. *Implicit negative patient material* refers to patient communications about the patient-therapist relationship which are not directly expressed. Patients may have thoughts and feelings about the therapist or therapy which they may not be aware of or which they may not readily reveal as they find them embarrassing or fear the therapist's response. They may therefore be revealed symbolically. The rater should be alerted to the possibility of implicit references about the therapy or therapist by reference to: other professional carers; teachers, policemen or women and other authority or parental figures; institutions such as school (learning), hospital (caring); all manner of regular meetings and regular events; talking or sitting; searching for an understanding of things; change, feeling exposed, new things, journeys, strangers, unknown people, people who say little.

ii) Categories of Therapist Response

Therapists' responses may be divided into two broad categories, those which are **facilitative** and those which are **restrictive**. Facilitative responses communicate a sensitivity to patients' thoughts and feelings and a wish to explore and understand them, both those expressed overtly and those expressed covertly. They therefore facilitate further discussion or reflection. On the other hand restrictive responses close the matter in avoidant or therapeutically unhelpful ways. The therapist may for example ignore or in some other way avoid what has been said or implied, act in an angry, retaliative or punitive manner toward the patient, act defensively or try and close the subject.

Facilitative responses may be demonstrated by various therapist interventions:

Gathering information -actively trying to understand a patient's thoughts, feelings or behaviour. This may be demonstrated, for example, by asking for further information and/or seeking clarification or by rephrasing or summarising what the patient said.

Therapeutic Alliance - encouraging a patient to join with the therapist in, for example, the process of gaining insight into their difficulties or of problem solving or of guiding the patient to their own interpretations or conclusions.

Focusing on underlying mental content - e.g. pointing to or challenging automatic thoughts or through analytic interpretation of unconcious material. Such focusing may be of many variants e.g.

transference interpretations - statements about what the patient is thinking or feeling at that moment within the patient-therapist relationship.

thematic interpretations - drawing comparison between current thoughts or feelings and thoughts or feelings experienced in other situations and at other times

automatic thoughts - pointing to a patient's automatic thoughts

intrapersonal links - pointing to a relationship between a patient's affective state and their thoughts

assumptions - pointing to underlying assumptions

Table 4.2 The Therapist Response (Facilitative-Restrictive) Rating Scale

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+3 - therapist directly and overtly refers to the patient's negative material in a facilitative way which furthers understanding or insight

+2 - therapist directly and overtly refers to the patient's negative material in a mildly facilitative way which may include seeking clarification or further information, or rephrasing or summarising what the patient has said, or facilitates further exploration of underlying conflict in a more general manner or expands on the nature of the difficulty in a more general manner

+1 - therapist facilitates further exploration whilst not directly addressing the patients negative material about the therapy/therapist.

0 - no direct response - therapist does not respond directly to the patients negative comment about the therapist/therapy nor facilitates further exploration through general observation pertinent to the patient's negative comment

-1 - therapist responds in a way which gently inhibits further consideration of the patient's negative comment about the therapist/therapy

-2 - therapist responds in a way which inhibits further consideration of the patient's negative comment about the therapist/therapy and which may be a little dismissive or antagonistic to those comments

-3 - therapist directly and overtly resists exploration of the patients negative comments about the therapist/therapy and does so in a dismissive or antagonistic way

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Confrontation - such as helping a patient to acknowledge affect they are not expressing or pointing to such avoidance

General Facilitation - generally eliciting or promoting a patient's acknowledgement of, or expression of, their negative feelings/reactions

There may be a narrow and subtle line between using such techniques in a facilitative manner and using them in a restrictive way. For example questioning the accuracy of a patient's negative view of therapy may be a legitimate and therapeutic pointing to of a schema driven distortion of the patient-therapist relationship. It may in turn parallel such distortions in other relationships in the patient's life over time and be relevant to the factors which led to the patient seeking therapy. However it may be delivered in such a way or at such a time as to be restrictive, stopping reflection or further exploration.

Restrictive responses may also be demonstrated in various ways by a therapist:.

No feedback - no attempt by the therapist to encourage expression or exploration of thoughts, feelings or behaviour or of gaining insight into them.

No understanding - the therapist ignores or dismisses the patient's comments or misses or fails to develop their main point.

No interpersonal effectiveness - the therapist is patronising or condescending, or critical or disapproving, or ridiculing or hostile, as opposed to being warm and concerned; is distant or cold; or evades the patient's questions.

4.6 Procedure

4.6.1 Obtaining audiotapes and videotapes

The pilot study had approached by letter more than 100 individuals and institutions in six countries, each having been identified because of their expertise in one of the major psychological therapies (see page 48). These approaches secured approximately 150 audiotaped and videotaped sessions of complete treatments across cognitive-behavioural, cognitive, conversational and psychodynamic therapies. Of these approximately 50 were used in the pilot study. Subsequent to

the pilot study a further 58 tapes were secured. Of these the majority were of the two major psychological therapies not researched in the pilot study i.e. behaviour therapy and psychoanalytic psychotherapy. The remainder were further sessions of psychodynamic psychotherapy. As in the pilot study all tapes were of the naturally occurring therapy of patients being treated in the National Health Service. Each treatment was delivered by a therapist who was a National Health Service specialist in the therapy they offered. None were of therapies specially conducted for this research. All tapes involved patients who had given consent for recordings of their treatment to be used for research purposes. The confidentiality of information used in the research was preserved by deleting all references that would allow identification of patients, by secure storage of all research media, and by strictly limiting access to session tapes.

4.6.2 Allocation of therapy tapes to treatment conditions

The selection and allocation of therapists to therapy conditions was, as in the pilot study, designed to reflect the study's intention to research naturally occurring differences between the major psychological therapies as applied in skilled daily clinical practice (see page 49). Selection of each therapist was therefore on the basis of their recognised training and expertise in one of the major psychological therapies and their work within the National Health Service as a specialist in this therapy model. Allocation of each therapist to a specific therapy condition was not randomised but deliberate on the basis of their expertise and specialism in that therapy.

4.6.3 Transcribing and rating the tapes of therapy sessions

Detailed verbatim transcriptions, including paralinguistics, were made of 88 taped complete sessions drawn equally from the six therapy types (behaviour, cognitive-behaviour, cognitive, conversational, psychodynamic and psychoanalytic) and within each type equally from sessions early and late in treatment. Early sessions were drawn from the first five, but not the first session, and late sessions from the last five, but not the last session. The exception to this was with late sessions in the psychoanalytic psychotherapy group which were taken from the last two months of therapies all of which exceeded two years.

Transference Coding System

All patient and all therapist statements in the 88 transcriptions were coded using the Transference Coding System. Each statement was rated separately, that is without reference to previous statements, with the exception that it was permissible to look to the previous statement to clarify what was being referred to in the statement currently being rated. Each statement was also rated

completely i.e. for all potential transference components, before moving on to the next statement. Transference codes were annotated in the transcription margins as they were rated and then, after rating, transferred to a coding sheet from which they were entered into a computerised data matrix on SPSS Base Version 8.

Following rating of the transcriptions interrater reliability and absence of bias in rating were checked by an independent rater coding a random sample of transcripts. Twelve of the 88 session transcriptions were selected by stratified random sampling; two transcriptions being taken from each of the six stratum (therapy groups). The independent rater, an experienced Clinical Nurse Specialist in Psychotherapy trained in both cognitive-behaviour and psychodynamic therapy, was trained in the use of the coding system before undertaking the rating. This training included conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings followed by discussion meetings with the author.

Coding System of Therapeutic Focus

Four transcriptions, consisting of one early session and one late session from each of two patients, were taken from each therapy group. All therapist statements in each of these 24 transcriptions were then coded for therapist focus using the Coding System of Therapeutic Focus. Each session was coded in four separate waves: general interventions, then components of patient functioning, then intrapersonal and interpersonal links, and lastly context (time frame and people involved) and time links and person links. General interventions and intrapersonal and interpersonal links were annotated in the left margin; time frames, people involved, time links and person links were annotated in the right margin; and components of patient functioning were written above the underlined word or phrase to which they referred. After all the sessions had been rated codes were transferred to a coding sheet from which they were then entered into a computerised data matrix on SPSS Base Version 8.

As with the Transference Coding System ratings, interrater reliability and absence of bias in rating were checked by an independent rater coding a random sample of transcripts. Twelve of the 24 rated session transcriptions were selected by stratified random sampling; two transcriptions being taken from each of the six stratum (therapy groups). The independent rater, an experienced National Health Service psychotherapist trained in both cognitive-behaviour and psychodynamic therapy, was trained in the use of the coding system before undertaking the rating. This training included familiarisation with the system's Training and Rater's manuals, conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings followed by discussion meetings with the author.

Therapist Response to Negative Patient Material

The same 24 transcriptions of therapy sessions that were rated using the Coding System of Therapeutic Focus were also used to research therapist response to patient negative material. Thus these 24 sessions consisted of four transcriptions, one early in treatment session and one late in treatment session from each of two patients, drawn from each of the six therapy groups. All patient utterances in these transcriptions which contained negative comment, implicit or explicit, about therapy or therapist were identified. Each of these negative references was then given a confidence rating on a scale from one to seven, one being *uncertain* and seven being *definite.* Therapists' responses to these negative comments were then rated as to how facilitative or restrictive they were in terms of consideration of the negative material. The rating scale (see Table 4.2) ranges along a continuum from -3 (restrictive) through 0 (no response) to +3 (facilitative). Where there was more than one negative reference rated in a patient's turn the highest possible patient reference was noted, an implicit reference rated one being low and an explicit rated seven being high. Where there was more than one therapist response rated within a turn, the highest possible response was noted, where -3 is low and +3 high. This rating was of the therapist's immediate response. Thus a therapist may have noted a negative comment but given no recognition of having done so in his immediate turn and then come back to it later. His immediate turn was not rated as facilitative.

In addition to the above codings data were taken from each session on the number of lines of each patient and each therapist statement and the number of patient and number of therapist statements per session.

As with the ratings of transcriptions using the Transference Coding System and the Coding System of Therapeutic Focus, interrater reliability and absence of bias in rating were checked by an independent rater. This independent rater, a psychologist, was familiarised with the research and trained in the use of the *Facilitative-Restrictive Rating Scale.* The training included conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings followed by discussion meetings with the author. She then analysed all 24 of the previously rated transcriptions with respect to both the presence of explicit and implicit negative comments by the patient about the therapist/therapy and the coding of therapists' responses to those comments.

CHAPTER 5

RESULTS

THE OCCURRENCE OF TRANSFERENCE REFERENCES

Data are presented first which give information on the reliability of the coding of references to transference components. Brief descriptive data is then given on the therapy sessions from which data were obtained. Results are then presented where the main effect analysed was the type of therapy. These results give information about:

i) the occurrence in the various therapies of references to each of the individual transference components. This is considered separately for patient statements and for therapist statements and considers both explicit references and implicit references to the transference components.

ii) the number of different types of transference components referred to in each patient and each therapist statement. This analysis looks at explicit references, implicit references, and at explicit and implicit references combined.

iii) which individual transference components are linked together within patient statements and within therapist statements and how frequently they are linked together. This is considered for both the linking of explicit references and for the linking of explicit and implicit references combined.

After this presentation of results, in which the main effect analysed was the type of therapy, results are then given where the main effect analysed was session order, i.e. the comparison across therapies of sessions from early in therapy with those from late in therapy, and the interaction of this with type of therapy. These results give information about:

i) the occurrence in the various therapies and across early and late sessions of therapy of references to each of the individual transference components. This is considered separately for patient statements and for therapist statements and considers both explicit references and implicit references to the transference components.

ii) the consideration across early and late sessions of therapy and therapy type of which individual transference components are linked together within patient statements and within therapist statements and how frequently they are linked together. This is considered for both the linking of explicit references and for the linking of explicit and implicit references combined.

In investigating the effect of therapy type analyses were undertaken not just across the six therapy groups: behaviour, cognitive-behaviour, cognitive, conversational, psychodynamic and psychoanalytic but also across the two therapy groupings: cognitive-behaviour (behaviour, cognitive-behaviour and cognitive) and psychodynamic (conversational, psychodynamic and psychoanalytic).

In investigating the effect of session order the unit of analysis was the specific patient-therapist pair. Thus, sessions from early in therapy of a patient-therapist pair were compared with sessions from late in the same therapy. The early sessions were taken from the first five sessions of therapy but not the first and compared with late sessions taken from the last five sessions of therapy but not the last. The one exception to this was late sessions of psychoanalytic psychotherapy where sessions were taken from the last two months of therapies all of which exceeded two years.

Each of the results presented about the occurrence of transference references draws on one or more of three possible sources of data:

i) percentage - the percentage of patient or therapist statements in sessions which contain the type of reference(s) being analysed

ii) mean - the mean occurrence per patient or therapist statement of the type of reference (s) being analysed

iii) rate - the mean occurrence per patient or therapist line of narrative of the type of reference (s) being analysed.

Data were analysed using SPSSPC Version 8.0.

5.1 Reliability of Transference Coding System Ratings

Twelve transcriptions of therapy sessions included in the study and rated by the author were selected by stratified random sampling. Two transcriptions were randomly taken from each of the six stratum (therapy groups) researched. These 12 sessions were then rated by an independent rater, an experienced Clinical Nurse Specialist in Psychotherapy with 15 years post qualification experience of undertaking cognitive-behaviour and psychodynamic therapy with adults and in which he had trained. Prior to undertaking the rating he was trained in the use of the coding system. This training included conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings of transcriptions not used in the study followed by discussion meetings with the author. The ratings showed good reliability with high percentage agreements between raters overall and on both explicit and implicit patient and therapist references. These percentage agreements are presented in Table 5.1. As with interrater reliability analyses in the pilot study (see page 43) implicit references and references to current feelings tended to show a lower level of rater agreement. Both were nonetheless still within acceptable limits of agreement. The lower level of agreement on rating implicit references may be explained, as it was in the pilot study, by the degree of inference required in making such references. The lower level of agreement on rating current feelings may be explained by the importance of non-verbal behaviour, information on which was not available to the raters, in communicating emotion. The levels of percentage agreement achieved suggested good reliability and an absence of bias in the author's ratings.

Table 5.1 Percentage Agreements between raters on components of the transference coding system

Components	Code	Explicit	Implicit
Reference to therapist or therapy	(1)	96	78
Reference to caretaker (usually parent)	(3)	97	95
Reference to current feeling/thought/ behaviour/attitude etc.	(4)	83	81
Reference to childhood feeling/thought/ behaviour/attitude etc.	(6)	98	89
Reference to interpersonal or intrapersonal conflict	(7)	91	82

5.2 Descriptive Data on Therapy Sessions

i) Session Length

Cognitive therapy sessions (Group 3) averaged about an hour and ten minutes in length. Cognitive-behavioural therapy sessions (Group 2) and Conversational therapy sessions (Group 4) both averaged about an hour. Behaviour therapy sessions (Group 1) too averaged about an hour but these varied more widely in length between 10 minutes and an hour and a half. Short Term Psychodynamic Psychotherapy sessions (Group 5) and Psychoanalytic Psychotherapy sessions (Group 6) both averaged about 50 minutes.

The mean length in minutes of sessions across the six therapy groups is presented in Table 5.2.

Table 5.2. Length in Minutes of Sessions

Therapy Group	Mean	Standard Deviation
Behaviour	58.60	42.39
Cognitive-behaviour	56.24	20.64
Cognitive	69.37	21.27
Conversational	56.14	19.11
Psychodynamic	50.03	0.90
Psychoanalytic	50.00	0.60

ii) Word Length of Transcriptions

Cognitive therapy (Group 3) transcriptions were between 6500 and 12500 words in length with a mean of 9420 words and Behaviour therapy (Group1) transcriptions between 2200 and 13300 words in length with a mean of 9017. Cognitive-behavioural therapy (Group 2) transcriptions had a mean length of 7803 words varying between 5500 words and 10100 words and Conversational therapy (Group 4) a mean length of 6878 words varying in length between 5500 and 8000 words. The Psychodynamic psychotherapy (Group 5) transcriptions varied between 3000 and 7500 words in length with a mean of 4278 and the Psychoanalytic psychotherapy (Group 6) varied between 350 and 1150 words in length with a mean of 827. The large differences in session word length between cognitive-behaviour and psychodynamic therapies reflected, in part, their longer mean duration, but also reflected differences in therapist narrative. Cognitive-behaviour therapists tended

to say more 'per turn' than did psychodynamic psychotherapists, and often more than their patients. In addition, psychodynamic psychotherapy sessions had more periods of apparent reflection in which neither patient or therapist spoke.

The mean length in words of sessions across the six therapy groups is presented in Table 5.3.

Table 5.3. Word Length of Session Transcriptions

Therapy Group	Mean	Standard Deviation
Behaviour	9017	6690
Cognitive-behaviour	7803	2748
Cognitive	9420	2868
Conversational	6876	1572
Psychodynamic	4278	1113
Psychoanalytic	827	212

Table 5.4. Number of Pairs of Patient-Therapist Statements in Sessions

Therapy Group	Mean	Standard Deviation
Behaviour	268	148
Cognitive-behaviour	110	41
Cognitive	175	53
Conversational	69	27
Psychodynamic	45	6
Psychoanalytic	6	2

iii) Number of Patient-Therapist Statements in Sessions

Behaviour therapy (Group 3) had a mean of 267.92 (SD 148.11) patient-therapist pairs of statements in sessions, Cognitive therapy 174.80 (SD 52.53) and Cognitive-behavioural therapy 109.70 (SD 41.81). The Conversational therapy group had a mean of 69.40 (SD 26.55) patient-therapist pairs of statements in sessions, the Psychodynamic psychotherapy group 44.74 (SD 6.42) and the Psychoanalytic 5.8 (SD 2.46). These differences reflect in part, as with session word length, the longer mean duration of cognitive-behaviour therapy sessions and that psychodynamic

psychotherapy sessions had more periods of silence. However, primarily the differences points to the shorter length of both patient and therapist 'turns' in cognitive-behaviour therapies.

The mean number of pairs of patient-therapist statements in sessions across the six therapy groups is presented in Table 5.4.

iv) Length of Patient and Therapist Statements in Sessions

In the Psychoanalytic psychotherapy group the mean length of patients' statements was 8.96 (SD 4.41) lines and therapists' statements 1.26 (SD 0.28) lines. The mean total length of patient utterances in a Psychoanalytic psychotherapy session was 46.53 (SD 14.01) lines and the mean total length of therapist utterances was 7.27 (SD 3.12) lines.

In the Psychodynamic psychotherapy group the mean length of patients' statements was 7.24 (SD 2.18) lines and therapists' statements 1.95 (SD 0.36) lines. The mean total length of patient utterances in a Psychodynamic psychotherapy session was 302.30 (SD 90.57) lines and the mean total length of therapist utterances was 84.77 (SD 17.48) lines.

The mean length of patients' statements in the Conversational therapy group was 6.01 (SD 2.42) lines and the mean length of therapists' statements was 2.49 (SD 0.64) lines. The mean total length of patient utterances in a Conversational therapy session was 373 (SD 110.66) lines and of therapist utterances 161.40 (SD 38.99) lines.

The mean length of patients' statements in the Cognitive-behavioural therapy group was 3.48 (SD 1.39) lines and the mean length of therapists' statements was 3.37 (SD 1.43) lines. The mean total length of patient utterances in a Cognitive-behavioural therapy session was 348.90 (SD 111.53) lines and of therapist utterances 332.80 (SD 89.45) lines.

In the Cognitive therapy group the mean length of patients' statements was 2.28 (SD 0.49) lines and therapists' statements 3.15 (SD 0.70) lines. The mean total length of patient utterances in a Cognitive therapy session was 383.90 (SD 90.36) lines and the mean total length of therapist utterances was 519.00 (SD 85.02) lines.

Patients' statements in the Behaviour therapy group had a mean length of 1.93 (SD 0.99) lines and therapists' statements 1.45 (SD 0.22) lines. The mean total length of patient utterances in a Behaviour therapy session was 446.50 (SD 207.08) lines and of therapist utterances 397.17 (SD 253.87) lines.

The mean number of lines in patient and in therapist statements in sessions across the six therapy groups is presented in Table 5.5. The mean total number of lines in patient and in therapist statements in sessions across the six therapy sessions is presented in Table 5.6.

Table 5.5. The Length (number of lines) of Patient and Therapist Statements in Sessions

	Patient		Therapist	
Therapy Group	**Mean**	**SD**	**Mean**	**SD**
Behaviour	1.93	0.99	1.45	0.22
Cognitive-behaviour	3.48	1.39	3.37	1.43
Cognitive	2.28	0.49	3.15	0.70
Conversational	6.01	2.42	2.49	0.64
Psychodynamic	7.24	2.18	1.95	0.36
Psychoanalytic	8.96	4.41	1.26	0.28

Table 5.6. The Total Length (number of lines) of Patient and Therapist Statements per Session

	Patient		Therapist	
Therapy Group	**Mean**	**SD**	**Mean**	**SD**
Behaviour	446.50	207.80	397.17	253.87
Cognitive-behaviour	348.90	111.53	332.80	89.45
Cognitive	383.90	90.36	519.00	85.02
Conversational	373.00	110.66	161.40	38.99
Psychodynamic	302.30	90.57	84.77	17.48
Psychoanalytic	46.53	14.01	7.27	3.12

5.3 The Occurrence of Transference References Across Therapies

5.3.1 Patient Statements - Individual Transference Components

Results are presented of the percentages of patient statements containing references to the various individual transference components and of the mean occurrence per line of patient narrative (rate) of such references.

The percentage of statements by patients across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, in which each of the 10 potential references to transference components were made are presented in Table 5.7. Percentages are also presented, in Table 5.8, of references made analysed across the six therapy groups.

The rate of references to each of the transference components made by patients across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.9. These rates analysed across the six therapy groups are presented in Table 5.10.

i) Explicit References by Patients

This section of analyses includes testing of the hypotheses that:

i) explicit patient references to transference components will occur in all therapies

ii) explicit patient references to transference components will, with the exception of to current feelings, occur more in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping

iii) there will be no significant difference in the occurrence of explicit patient references to current feelings across the Psychodynamic and Cognitive-behaviour grouping of therapies

iv) explicit patient references, with the exception of to current feelings, will occur more in the Psychoanalytic and Psychodynamic psychotherapy groups than in other groups

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the percentage of patient statements containing explicit references to transference components across the two groupings of therapies, Psychodynamic (Conversational, Psychodynamic and Psychoanalytic) and Cognitive-behaviour (Behaviour, Cognitive-behaviour and Cognitive). These tests showed Psychodynamic therapies to contain a significantly higher percentages of statements containing references than Cognitive-behaviour to all components: therapist ($t(86) = 7.250$), $p<0.001$), parent ($t(86) = 3.229$, $p<0.005$), current feeling ($t(86) = 9.897$, $p<0.001$), childhood feeling ($t(86) = 2.188$, $p<0.05$) and conflict ($t(86) = 4.997$, $p<0.001$). They also showed a significantly higher rate of references than did Cognitive-behaviour therapies to: therapist ($t(86) = 5.935$, $p<0.001$), parent ($t(86) = 3.294$, $p<0.001$), current feeling ($t(83.974) = 2.668$, $p<0.01$) and conflict ($t(85.830) = 2.700$, $p<0.01$).

Table 5.7. The percentage of patient statements across the two therapy groupings in which each of the 10 transference components were identified (standard deviation in brackets).

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent				
Patient Explicit Reference to:				
Therapist	4.07	(3.36)	30.69	(18.05)
Parent	2.51	(3.48)	15.09	(14.79)
Current feeling	66.68	(13.14)	82.05	(9.89)
Past feeling	1.86	(3.13)	7.60	(11.82)
Conflict	6.38	(6.73)	20.85	(12.93)
Patient Implicit Reference to:				
Therapist	15.19	(9.98)	30.88	(19.63)
Parent	1.91	(2.30)	15.92	(17.87)
Current feeling	4.00	(2.18)	11.44	(13.82)
Past feeling	3.22	(3.68)	15.47	(13.81)
Conflict	8.35	(3.74)	27.11	(17.59)

The Six Therapy Groups

A one-way ANOVA for the percentage of statements containing explicit references made by patients about the therapist showed an overall significant effect of type of therapy ($F(5, 82) = 20.500$, $p<0.001$). A priori contrasts showed significantly more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 7.701$, $p<0.001$), Cognitive-behaviour ($t(82) = 6.722$, $p<0.001$), Cognitive ($t(82) = 6.424$, $p<0.001$) and Conversational ($t(82) = 4.486$, $p<0.001$) therapy groups. A further series of a priori contrasts showed the Psychodynamic psychotherapy group contained a higher percentage of patient statements containing explicit references about the therapist than in the Behaviour ($t(82) = 6.282$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.218$, $p<0.001$), Cognitive ($t(82) = 4.883$, $p<0.001$) and Conversational ($t(82) = 2.708$, $p<0.01$) therapy groups.

A one-way ANOVA for the rate of references about the therapist also showed an overall significant effect of type of therapy ($F(5, 82) = 9.411$, $p<0.001$). A priori contrasts showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 4.999$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.294$, $p<0.001$), Cognitive ($t(82) = 3.516$, $p<0.001$) and Conversational ($t(82) = 2.794$, $p<0.01$) therapy groups. A further series of a priori contrasts showed the Psychodynamic psychotherapy group to have a

higher rate of references about the therapist than in the Behaviour ($t(82) = 4.835$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.017$, $p<0.001$), Cognitive ($t(82) = 3.144$, $p<0.005$) and Conversational ($t(82) = 2.333$, $p<0.05$) therapy groups.

Table 5.8. The percentage of patient statements across the six therapy groups in which each of the 10 transference components were identified (standard deviation in brackets).

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Referent					
Patient Explicit Reference to:					
Therapist	1.56	4.73	6.35	16.88	29.99	41.26
	(1.35)	(2.33)	(4.01)	(11.98)	(14.23)	(22.26)
Parent	2.65	2.63	2.22	6.73	13.36	24.23
	(4.44)	(3.24)	(2.66)	(5.45)	(12.71)	(18.64)
Current feeling	68.61	64.50	66.56	79.37	79.76	88.56
	(13.68)	(15.17)	(11.28)	(7.04)	(6.92)	(13.71)
Past feeling	2.20	1.01	2.30	3.58	5.17	15.31
	(3.92)	(1.31)	(3.47)	(2.94)	(7.66)	(18.15)
Conflict	2.37	10.19	7.40	17.00	16.37	32.64
	(2.31)	(9.33)	(4.87)	(7.03)	(9.28)	(15.48)
Patient Implicit reference to:						
Therapist	6.58	22.30	18.67	29.25	22.24	49.42
	(3.98)	(11.71)	(3.58)	(9.22)	(11.05)	(25.87)
Parent	0.13	3.44	2.59	9.14	10.33	32.00
	(0.23)	(2.11)	(2.51)	(7.53)	(8.80)	(25.95)
Current feeling	3.39	4.35	4.38	10.13	8.06	19.31
	(1.70)	(1.63)	(3.05)	(5.64)	(5.64)	(23.89)
Past feeling	0.48	6.14	3.57	13.06	13.62	20.91
	(0.87)	(4.07)	(3.11)	(10.02)	(8.44)	(22.11)
Conflict	7.12	8.20	9.99	15.89	25.34	38.25
	(2.31)	(4.50)	(4.08)	(5.50)	(8.82)	(28.29)

A one-way ANOVA for the percentage of patient statements containing explicit references about parents showed an overall significant effect of the type of therapy ($F(5, 82) = 8.345$, $p<0.001$). A priori contrasts showed significantly more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 4.960$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.709$, $p<0.001$), Cognitive ($t(82) = 4.799$, $p<0.001$) and Conversational ($t(82) = 3.816$, $p<0.001$) therapy groups. A further series of a priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of patient statements containing explicit references to parents than did the Behaviour ($t(82) = 2.802$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.624$, $p<0.01$) and Cognitive ($t(82) = 2.725$, $p<0.01$) therapy groups.

A one-way ANOVA for the rate of references about parents also showed an overall significant effect of type of therapy ($F(5, 82) = 4.703$, $p<0.001$). A priori contrasts showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 3.530$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.500$, $p<0.001$), Cognitive ($t(82) = 3.709$, $p<0.001$) and Conversational ($t(82) = 3.279$, $p<0.005$) therapy groups. A further series of a priori contrasts showed a significantly higher rate of patient explicit references to parents were also made in the Psychodynamic compared with the Cognitive therapy group ($t(82) = 2.021$, $p<0.001$).

A one-way ANOVA for the percentage of patient statements containing explicit references to current feelings or thoughts showed an overall significant effect of the type of therapy ($F(5, 82) = 33.295$, $p<0.001$). Further analyses showed significantly more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$) and Conversational (Scheffe test, $p<0.001$) therapy groups. These further analyses also showed that the Psychodynamic psychotherapy group contained a higher number of such references than did the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$) and Cognitive (Scheffe test, $p<0.001$) therapy groups.

A one-way ANOVA for the rate of references about current feelings or thoughts also showed an overall significant effect of type of therapy ($F(5, 82) = 4.111$, $p<0.01$). However, further analyses did not show significant differences between any two groups.

A one-way ANOVA for the percentage of patient statements containing explicit references to childhood feelings or thoughts showed an overall significant effect of the type of therapy ($F(5, 82) = 4.663$, $p<0.001$). A priori contrasts showed a significantly higher percentage of patient statements containing explicit references to childhood feelings in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 3.731$, $p<0.001$), Cognitive-behaviour, ($t(82) = 3.861$, $p<0.001$), Cognitive ($t(82) = 3.513$, $p<0.001$) and Conversational ($t(82) = 3.167$, $p<0.01$) therapy groups.

A one-way ANOVA for the rate of references about childhood feelings or thoughts also showed an overall significant effect of type of therapy ($F(5, 82) = 2.519$, $p<0.05$). A priori contrasts showed a higher rate of references to childhood feelings in the Psychoanalytic psychotherapy group than in the Cognitive-behaviour ($t(82) = 2.893$, $p<0.005$), Cognitive ($t(82) = 2.305$, $p<0.05$) and Conversational ($t(82) = 2.522$, $p<0.05$) therapy groups.

A one-way ANOVA for the percentage of statements containing references to conflict showed an overall significant effect of type of therapy ($F(5, 82) = 16.571$, $p<0.001$). A priori contrasts showed the Psychoanalytic psychotherapy group to contain a significantly higher percentage than the Behaviour ($t(82) = 8.238$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.296$, $p<0.001$), Cognitive ($t(82) = 6.516$, $p<0.001$), Conversational ($t(82) = 4.038$, $p<0.001$) and Psychodynamic ($t(82) = 5.451$, $p<0.001$) therapy groups. A further series of a priori contrasts showed the Psychodynamic psychotherapy group to contain a significantly higher percentage than the Behaviour ($t(82) = 4.341$, $p<0.001$) and Cognitive ($t(82) = 2.600$, $p<0.05$) therapy groups.

A one-way ANOVA for the rate of references to conflict also showed an overall significant effect of type of therapy ($F(5, 82) = 3.803$, $p<0.005$). A priori contrasts showed a significantly higher rate of patient explicit references to conflict in the Psychoanalytic psychotherapy group than in the

Table 5.9. The rate at which each of the 10 transference components was identified by patients across the two therapy groupings (standard deviation in brackets).

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Referent		
Patient Explicit Reference to:		
Therapist	0.017 (0.014)	0.069 (0.049)
Parent	0.013 (0.018)	0.040 (0.044)
Current feeling	0.430 (0.114)	0.511 (0.172)
Past feeling	0.010 (0.019)	0.016 (0.033)
Conflict	0.025 (0.020)	0.042 (0.038)
Patient Implicit Reference to:		
Therapist	0.069 (0.038)	0.071 (0.053)
Parent	0.007 (0.006)	0.025 (0.025)
Current feeling	0.020 (0.013)	0.020 (0.023)
Past feeling	0.012 (0.012)	0.026 (0.019)
Conflict	0.056 (0.094)	0.053 (0.036)

Behaviour ($t(82) = 4.239$, $p<0.001$), Cognitive-behaviour, ($t(82) = 2.481$, $p<0.05$), Cognitive ($t(82) = 2.341$, $p<0.05$) and Conversational ($t(82) = 2.170$, $p<0.05$) therapy groups. A further series of a priori contrasts showed the Psychodynamic psychotherapy group to contain a significantly higher rate of references than the Behaviour therapy group ($t(82) = 2.001$, $p<0.05$).

No other analyses of patients' explicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Table 5.10. The rate at which each of the 10 transference components was identified by patients across the six therapy groups (standard deviation in brackets).

Group	Behaviour		Cognitive		Psychodynamic	
Referent		Cog.-beh.		Conversational		Psychoanalytic
Patient Explicit Reference to:						
Therapist	0.009	0.016	0.028	0.039	0.072	0.083
	(0.008)	(0.007)	(0.017)	(0.028)	(0.042)	(0.064)
Parent	0.015	0.013	0.010	0.016	0.036	0.064
	(0.022)	(0.020)	(0.012)	(0.016)	(0.036)	(0.061)
Current feeling	0.514	0.396	0.363	0.405	0.520	0.564
	(0.077)	(0.116)	(0.091)	(0.078)	(0.124)	(0.260)
Past feeling	0.016	0.003	0.010	0.008	0.010	0.036
	(0.028)	(0.004)	(0.015)	(0.007)	(0.016)	(0.057)
Conflict	0.012	0.032	0.034	0.036	0.033	0.063
	(0.007)	(0.023)	(0.022)	(0.015)	(0.022)	(0.061)
Patient Implicit reference to:						
Therapist	0.039	0.082	0.090	0.079	0.048	0.113
	(0.021)	(0.043)	(0.024)	(0.034)	(0.021)	(0.080)
Parent	0.001	0.011	0.011	0.016	0.018	0.047
	(0.001)	(0.005)	(0.010)	(0.012)	(0.013)	(0.036)
Current feeling	0.021	0.017	0.021	0.020	0.016	0.030
	(0.014)	(0.010)	(0.016)	(0.012)	(0.011)	(0.041)
Past feeling	0.002	0.019	0.015	0.024	0.026	0.028
	(0.003)	(0.012)	(0.011)	(0.019)	(0.014)	(0.027)
Conflict	0.087	0.030	0.044	0.032	0.054	0.068
	(0.151)	(0.016)	(0.018)	(0.013)	(0.027)	(0.055)

Summary

Explicit references by patients

Support was obtained for the hypothesis that explicit references to all transference components would occur in all therapies.

Support was obtained for the hypothesis that explicit references would be higher in the Psychodynamic than the Cognitive-behaviour grouping of therapies.

Support was not obtained for the hypothesis that there would be no significant difference in explicit references to current feelings across the Psychodynamic and Cognitive-behaviour

grouping of therapies. Explicit references to current feelings were higher in the Psychodynamic grouping of therapies.

Support was obtained for the hypothesis that explicit references (except to current feelings) would be higher in the Psychoanalytic psychotherapy group than the Conversational, Cognitive, Cognitive-behaviour and Behaviour therapy groups.

Partial support was obtained for the hypothesis that explicit references (except to current feelings) would be higher in the Psychodynamic psychotherapy group than in the other therapy groups. Explicit references to the therapist and to parents were higher in the Psychodynamic psychotherapy group than the Cognitive, Cognitive-behaviour and Behaviour therapy groups and explicit references to conflict higher than in the Behaviour and Cognitive therapy groups.

ii) Implicit References by Patients

This section of analyses includes testing of the hypotheses that:

i) implicit patient references to transference will occur in all therapies

ii) implicit patient references to transference will occur more in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping

iii) implicit patient references to the therapist and conflict in the Cognitive-behaviour grouping of therapies will be higher than their respective explicit references because explicit references to them will not be facilitated.

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the percentage of patient statements containing implicit references to transference components across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher percentage than Cognitive-behaviour to all components: therapist ($t(86) = 4.603$, $p<0.001$), parent ($t(86) = 4.373$, $p<0.001$), current feeling ($t(86) = 3.055$, $p<0.005$), childhood feelings ($t(86) = 4.871$, $p<0.001$) and conflict ($t(86) = 5.199$, $p<0.001$).

Independent Samples t-Tests were also used to compare the rate of implicit references across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of references than did Cognitive-

behaviour therapies to: parent ($t(86) = 4.054$, $p<0.001$) and to past feeling ($t(86) = 3.888$, $p<0.001$).

Related Samples t-Tests were used to compare the percentage of patient statements containing explicit references to the therapist and to conflict with the percentage containing implicit references in the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed the Cognitive-behaviour grouping to contain a significantly higher percentage of statements containing implicit as opposed to explicit references to the therapist ($t(31) = 7.537$, $p<0.001$).

Related Samples t-Tests were used to compare the rate of patient explicit and implicit references to the therapist and to conflict in the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed the Cognitive-behaviour grouping to contain a significantly higher rate of implicit references as opposed to explicit references to the therapist ($t(31) = 8.751$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for the percentage of patient statements containing implicit references about the therapist showed an overall significant effect of type of therapy across the six therapy groups ($F(5, 82) = 16.493$, $p<0.001$). Further analyses showed significantly higher percentages of statements in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$) Conversational (Scheffe test, $p<0.005$) and Psychodynamic (Scheffe test, $p<0.001$) therapy groups.

A one-way ANOVA for the rate of references about the therapist also showed an overall significant effect of type of therapy across the six therapy groups ($F(5, 82) = 7.070$, $p<0.001$). Further analyses showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.005$) and the Psychodynamic (Scheffe test, $p<0.001$) therapy groups.

A one-way ANOVA for the percentage of patient statements containing implicit references about parents showed an overall significant effect of the type of therapy ($F(5, 82) = 10.954$, $p<0.001$). Further analyses showed significantly higher percentages of statements in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe

test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.005$) and Psychodynamic (Scheffe test, $p<0.001$) therapy groups.

A one-way ANOVA for the rate of references about parents also showed an overall significant effect of type of therapy ($F(5, 82) = 11.229$, $p<0.001$). Further analyses showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.005$) and Psychodynamic (Scheffe test, $p<0.001$) therapy groups.

A one-way ANOVA for the percentage of patient statements containing implicit references made by patients about current thoughts and feelings showed an overall significant effect of the type of therapy ($F(5, 82) = 4.430$, $p<0.001$). Further analyses however showed no significant difference between any two therapy groups.

A one-way ANOVA for the rate of references about current feelings did not show any overall significant effect of type of therapy. Sub one-way ANOVAs did however show the Psychoanalytic and Psychodynamic psychotherapy groups to have a significantly higher rate of patient implicit references to current feelings than the Behaviour therapy group (Scheffe tests, $p<0.01$ and $p<0.005$ respectively).

A one-way ANOVA for the percentage of patient statements containing implicit references to childhood thoughts and feelings showed an overall significant effect of the type of therapy ($F(5, 82) = 5.166$, $p<0.001$). Further analyses however showed no significant difference between any two therapy groups.

A one-way ANOVA for the rate of patient implicit references to childhood feelings and thoughts showed an overall significant effect of type of therapy ($F(5, 82) = 4.625$, $p<0.001$) but post hoc tests showed no significant difference between any two groups.

A further one-way ANOVA investigating the percentage of patient statements containing implicit references to conflict showed an overall significant effect of type of therapy ($F(5, 82) = 10.046$, $p<0.001$). Post hoc tests showed a significantly higher percentage of statements in the Psychoanalytic psychotherapy group contained implicit references to conflict than the Behaviour

(Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$) and Conversational (Scheffe test, $p<0.05$) therapy groups.

A one-way ANOVA for the rate of patient implicit references to conflict showed an overall significant effect of type of therapy ($F(5, 82) = 4.625$, $p<0.001$) but post hoc tests showed no significant difference between any two groups.

Related Samples t-Tests were used to compare in the six therapy groups the percentage of patient statements containing explicit references to the therapist and to conflict with the percentage containing implicit references. These tests showed the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups to contain a significantly higher percentage of statements containing implicit as opposed to explicit references to the therapist ($t(11) = 3.552$, $p<0.005$; $t(9) = 5.418$, $p<0.001$; $t(9) = 13.932$, $p<0.001$; and $t(9) = 2.850$, $p<0.05$ respectively). The tests also showed the Psychodynamic psychotherapy group to contain a significantly higher percentage of statements containing explicit as opposed to implicit references to the therapist ($t(30) = 2.574$, $p<0.05$). The Behaviour and Psychodynamic therapy groups both contained a significantly higher percentage of statements containing implicit as compared with explicit references to conflict ($t(11) = 4.461$, $p<0.001$ and $t(30) = 3.869$, $p<0.001$ respectively).

Related Samples t-Tests were used to compare in the six therapy groups the rate of patient explicit references to the therapist and to conflict with the rate of implicit references. These tests showed the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups to contain a significantly higher rate of implicit as opposed to explicit references to the therapist ($t(11) = 4.405$, $p<0.001$; $t(9) = 5.079$, $p<0.001$; $t(9) = 9.132$, $p<0.001$; and $t(9) = 2.978$, $p<0.001$ respectively). The tests also showed the Psychodynamic psychotherapy group to contain a significantly higher rate of explicit as opposed to implicit references to the therapist ($t(30) = 3.221$, $p<0.005$). With the exception of the Psychodynamic group which contained a significantly higher rate of implicit as compared with explicit references to conflict ($t(30) = 3.221$, $p<0.005$) no other therapy group had a significant difference in explicit and implicit references to conflict.

No other analyses of patients' implicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Implicit references by patients

Support was obtained for the hypothesis that implicit references to all transference components would occur in all therapies.

Support was obtained for the hypothesis that implicit references would be higher in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping.

Support was obtained for the hypothesis that implicit references to the therapist would be higher than explicit references to the therapist in the Cognitive-behaviour grouping of therapies.

Support was not obtained for the hypothesis that implicit references to conflict would be higher than explicit references to conflict in the Cognitive-behaviour grouping of therapies.

Implicit references to the therapist and to parents were higher in the Psychoanalytic group than in all other groups.

Implicit references to conflict were higher in the Psychoanalytic group than in the Behaviour, Cognitive-behaviour and Cognitive groups.

Implicit references to the therapist were higher than explicit in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups.

Implicit references to the therapist were lower than explicit in the Psychodynamic psychotherapy group.

Implicit references to conflict were higher than explicit in the Psychodynamic psychotherapy group.

iii) The Ratio of Explicit to Implicit References in Patient Statements

Results are presented of the ratio of the percentage of patient statements containing explicit references to each transference component to the percentage containing implicit references. Table 5.11 presents these ratio analysed across the two groupings, Cognitive-behaviour therapies and

Psychodynamic psychotherapies and Table 5.12 these ratios analysed across the six therapy groups.

Results are also presented of the ratio of explicit and implicit references as a function of the mean occurrence per patient statement of such references. Table 5.13 presents these ratio analysed across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies and Table 5.14 these ratios analysed across the six therapy groups.

Table 5.11. The Ratio of the Percentage of Patient Statements Containing Explicit References to Patient Statements Containing Implicit References to Transference Components, Analysed Across the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Ratio of Explicit to Implicit References to				
Therapist	0.308	(0.260)	1.295	(0.912)
Parent	3.108	(6.698)	1.510	(2.179)
Current feeling	29.299	(36.547)	9.931	(7.600)
Past feeling	0.758	(1.368)	0.343	(0.387)
Conflict	0.896	(1.501)	0.898	(0.669)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the ratio of the percentages of patient statements containing explicit to the percentage containing implicit references to transference components across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic grouping of therapies to contain a significantly higher explicit to implicit ratio of references than Cognitive-behaviour to the therapist ($t(86) = 5.970$, $p<0.001$). The Cognitive-behaviour grouping of therapies contained a significantly higher explicit to implicit ratio of references to current feeling ($t(86) = 3.460$, $p<0.001$).

Independent Samples t-Tests were also used to compare the ratio of the mean occurrence per patient statement of explicit references to the mean occurrence of implicit references across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher explicit to implicit ratio of references than did Cognitive-behaviour therapies to the therapist ($t(86) = 5.608$, $p<0.001$).

Table 5.12. The Ratio of the Percentage of Patient Statements Containing Explicit References to Patient Statements Containing Implicit References to Transference Components, Analysed Across the Six Therapy Groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Ratio of Explicit to Implicit References to						
Therapist	0.358	0.238	0.324	0.599	1.622	1.083
	(0.386)	(0.111)	(0.172)	(0.423)	(0.956)	(0.752)
Parent	14.889	1.196	0.791	2.101	1.641	0.688
	(12.729)	(1.857)	(1.056)	(2.946)	(2.264)	(0.556)
Current feeling	37.812	18.062	30.318	8.267	12.333	3.401
	(53.522)	(10.364)	(27.458)	(3.725)	(8.292)	(2.576)
Past feeling	1.626	0.148	0.873	0.388	0.314	0.389
	(2.097)	(0.176)	(1.413)	(0.353)	(0.398)	(0.417)
Conflict	0.382	1.622	0.787	1.139	0.751	1.064
	(0.425)	(2.525)	(0.456)	(0.411)	(0.616)	(0.875)

The Six Therapy Groups

A one-way ANOVA comparing, across the six therapy groups, the ratio of the percentages of patient statements containing explicit references to the therapist to the percentage containing implicit references showed an overall significant effect of type of therapy ($F(5, 82) = 12.106$, $p<0.001$). Further analyses showed the Psychodynamic psychotherapy group to contain a significantly higher explicit to implicit ratio of references to the therapist than the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$) and Conversational (Scheffe test, $p<0.01$) therapy groups.

A one-way ANOVA comparing, across the six therapy groups, the ratio of the mean occurrence per patient statement of explicit references to the therapist to the mean occurrence of implicit references to the therapist showed an overall significant effect of type of therapy ($F(5, 82) = 7.703$, $p<0.001$). Further analyses showed the Psychodynamic psychotherapy group to contain a significantly higher explicit to implicit ratio of references to the therapist than the Behaviour (Scheffe test, $p<0.005$), Cognitive-behaviour (Scheffe test, $p<0.005$) and Cognitive (Scheffe test, $p<0.01$) therapy groups.

A one-way ANOVA comparing, across the six therapy groups, the ratio of the percentages of patient statements containing explicit references to parents to the percentage containing implicit references showed an overall significant effect of type of therapy ($F(5, 82) = 12.032$, $p<0.001$).

Further analyses showed the Behaviour therapy group to contain a significantly higher explicit to implicit ratio of references to parents than the Cognitive-behaviour, Cognitive, Conversational, Psychodynamic and Psychoanalytic psychotherapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.01$ respectively).

A one-way ANOVA comparing, across the six therapy groups, the ratio of the mean occurrence per patient statement of explicit references to parents to the mean occurrence of implicit references parents showed an overall significant effect of type of therapy ($F(5, 82) = 11.102$, $p<0.001$). Further analyses showed the Behaviour therapy group to contain a significantly higher explicit to implicit ratio of references to parents than the Cognitive-behaviour, Cognitive, Conversational, Psychodynamic and Psychoanalytic psychotherapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.001$ respectively).

A one-way ANOVA comparing, across the six therapy groups, the ratio of the percentages of patient statements containing explicit references to current feelings to the percentage containing implicit references showed an overall significant effect of type of therapy ($F(5, 82) = 3.332$, $p<0.01$). However further analyses did not show any significant difference between any two groups.

Table 5.13. The Ratio of the Mean Occurrence Per Patient Statement of Explicit to Implicit References to Transference Components, Analysed Across the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Ratio of Explicit to Implicit References to				
Therapist	0.289	(0.240)	1.460	(1.326)
Parent	5.381	(12.466)	2.376	(4.322)
Current feeling	40.696	(46.658)	33.678	(26.412)
Past feeling	1.191	(2.254)	0.378	(0.481)
Conflict	0.951	(1.798)	0.934	(0.798)

A one-way ANOVA comparing, across the six therapy groups, the ratio of the mean occurrence per patient statement of explicit references to childhood feelings to the mean occurrence of implicit references to childhood feelings showed an overall significant effect of type of therapy (F

(5, 82) = 6.820, $p<0.001$). Further analyses showed the Behaviour therapy group to contain a significantly higher explicit to implicit ratio of references to such feelings than the Cognitive-behaviour, Conversational, Psychodynamic and Psychoanalytic psychotherapy groups (Scheffe tests, $p<0.001$, $p<0.05$, $p<0.001$, $p<0.001$ and $p<0.005$ respectively).

No other analyses of the ratio of explicit to implicit references by patients showed any significant differences either across the two therapy groupings or the six therapy groups.

Table 5.14. The Ratio of the Mean Occurrence Per Patient Statement of Explicit to Implicit References to Transference Components, Analysed Across the Two Therapy Groupings (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Ratio of Explicit to Implicit References to						
Therapist	0.333	0.219	0.307	0.580	1.829	1.286
	(0.352)	(0.116)	(0.158)	(0.499)	(1.264)	(1.563)
Parent	27.297	1.978	0.851	1.960	2.794	1.678
	(23.877)	(3.410)	(1.097)	(2.178)	(5.302)	(2.730)
Current feeling	49.914	34.046	36.284	20.980	42.591	16.770
	(67.488)	(23.704)	(34.433)	(8.602)	(28.088)	(20.141)
Past feeling	3.449	0.172	0.981	0.397	0.321	0.555
	(3.693)	(0.191)	(1.723)	(0.365)	(0.466)	(0.633)
Conflict	0.393	1.767	0.803	1.242	0.729	1.184
	(0.604)	(3.046)	(0.483)	(0.502)	(0.555)	(1.264)

Summary

Ratio of explicit to implicit references by patients

Implicit references about the therapist occurred more than explicit references in the Cognitive-behavioural grouping of therapies than the Psychodynamic.

Explicit references about the therapist occurred more than implicit references in the Psychodynamic grouping of therapies than the Cognitive-behavioural.

Implicit references about the therapist occurred more than explicit in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups than the Psychodynamic.

Explicit references about the therapist occurred more than implicit in the Psychodynamic and Psychoanalytic psychotherapy groups.

The Ratio of Explicit to Implicit references about the therapist was significantly higher in the Psychodynamic grouping of therapies than the Cognitive-behaviour.

The Ratio of Explicit to Implicit references to current feelings and thoughts was significantly higher in the Cognitive-behaviour grouping of therapies than the Psychodynamic.

The Ratio of Explicit to Implicit references about the therapist was significantly higher in the Psychodynamic psychotherapy group than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

The Ratio of Explicit to Implicit references to childhood feelings was higher in the Behaviour group than in the Cognitive-behaviour, Conversational, Psychodynamic and Psychoanalytic therapy groups.

The Ratio of Explicit to Implicit references to parents was higher in the Behaviour group than in the other five therapy groups.

5.3.2 Therapist Statements - Individual Transference Components

Results are presented of the percentages of therapist statements containing references to the various individual transference components and of the mean occurrence per line of therapist narrative (rate) of such references.

The percentage of statements by therapists across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, in which each of the 10 potential references to transference components were made are presented in Table 5.15. Percentages are also presented, in Table 5.16, of references made analysed across the six therapy groups.

The rate of references to each of the transference components made by therapists across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.17. These rates analysed across the six therapy groups are presented in Table 5.18.

i) Explicit References by Therapists

This section of analyses includes testing of the hypotheses that:

i) explicit therapist references to transference components will occur in all therapies

ii) explicit therapist references, with the exception of to current feelings and thoughts, will occur more in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping

iii) there will be no significant difference in the occurrence of explicit therapist references to current feelings across the Psychodynamic and Cognitive-behaviour grouping of therapies

iv) explicit therapist references to the therapist and to conflict will occur more in the Psychoanalytic and Psychodynamic psychotherapy groups than in other groups

v) explicit therapist references to parents and to childhood feelings will occur more in the Psychodynamic psychotherapy group than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the percentage of therapist statements containing explicit references to transference components across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher percentages of statements than Cognitive-behaviour therapies containing references to all components: therapist ($t(86) = 8.362$, $p<0.001$), parent ($t(86) = 4.273$, $p<0.001$), current feeling ($t(65.174) = 7.939$, $p<0.001$), childhood feelings ($t(86) = 3.311$, $p<0.001$) and conflict ($t(86) = 5.356$, $p<0.001$).

Independent Samples t-Tests were also used to compare the rate of explicit references across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of references than did Cognitive-behaviour therapies to all components: therapist ($t(86) = 7.544$ $p<0.001$), parent ($t(86) = 4.175$, $p<0.001$), current feeling ($t(86) = 11.526$, $p<0.001$), childhood feelings ($t(86) = 3.333$, $p<0.001$) and conflict ($t(86) = 5.228$, $p<0.001$).

Table 5.15. Percentage of therapist statements across the two therapy groupings in which each of the 10 transference components were identified (standard deviation in brackets).

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent				
Therapist Explicit Reference to:				
Therapist	2.37	(2.64)	23.59	(15.50)
Parent	1.18	(2.08)	10.12	(11.66)
Current feeling	39.75	(15.68)	67.41	(12.37)
Past feeling	0.33	(1.04)	3.65	(5.85)
Conflict	2.36	(3.31)	11.16	(8.98)
Therapist Implicit Reference to:				
Therapist	4.91	(5.66)	7.47	(8.17)
Parent	0.76	(1.45)	2.80	(3.75)
Current feeling	2.78	(2.77)	4.77	(5.58)
Past feeling	1.06	(1.78)	4.20	(4.54)
Conflict	2.14	(3.11)	12.29	(10.07)

The Six Therapy Groups

A one-way ANOVA for the percentage of therapist statements containing explicit references about the therapist showed an overall significant effect of type of therapy ($F(5, 82) = 16.092$, $p<0.001$) across the six therapy groups. A priori contrasts showed significantly higher percentages in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 5.107$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.600$, $p<0.001$), Cognitive ($t(82) = 4.256$, $p<0.001$) and Conversational ($t(82) = 2.125$, $p<0.05$) therapy groups. A series of further a priori contrasts showed significantly higher percentages also occurred in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 5.857$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.201$, $p<0.001$), Cognitive ($t(82) = 4.814$, $p<0.001$) and Conversational ($t(82) = 2.422$, $p<0.05$) therapy groups.

A one-way ANOVA for the rate of references about the therapist also showed an overall significant effect of type of therapy ($F(5, 82) = 17.574$, $p<0.001$). A priori contrasts showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 6.729$, $p<0.001$), Cognitive-behaviour ($t(82) = 6.400$, $p<0.001$), Cognitive ($t(82) = 6.266$, $p<0.001$) and Conversational ($t(82) = 4.487$, $p<0.001$) therapy groups. A series of further a priori contrasts showed a higher rate of references about the therapist in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 5.309$, $p<0.001$), Cognitive-

behaviour (t (82) = 4.982, p<0.001), Cognitive (t (82) = 4.831, p<0.001) and Conversational (t (82) = 2.835, p<0.01) therapy groups.

Table 5.16. Percentage of therapist statements across the six therapy groups in which each of the 10 transference components were identified (standard deviation in brackets).

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referent						
Therapist Explicit Reference to:						
Therapist	1.06	2.29	4.02	14.73	25.57	25.41
	(0.83)	(0.89)	(4.18)	(10.66)	(14.92)	(18.03)
Parent	0.32	1.51	1.87	4.85	12.38	8.95
	(0.46)	(2.86)	(2.19)	(5.08)	(10.81)	(15.33)
Current feeling	23.22	51.75	47.60	69.66	68.03	64.64
	(6.70)	(10.97)	(8.87)	(10.55)	(12.99)	(12.47)
Past feeling	0.04	0.06	0.95	2.99	3.61	4.19
	(0.14)	(0.19)	(1.74)	(3.39)	(5.50)	(7.86)
Conflict	0.10	3.75	3.67	7.76	10.63	14.51
	(0.20)	(4.65)	(2.32)	(6.07)	(6.65)	(13.32)
Therapist Implicit reference to:						
Therapist	0.09	7.89	7.72	13.15	6.01	6.69
	(0.26)	(7.44)	(2.27)	(7.50)	(5.12)	(11.89)
Parent	0.00	0.93	1.36	2.96	3.46	1.33
	(0.00)	(2.00)	(1.41)	(3.63)	(2.91)	(5.61)
Current feeling	0.93	3.94	3.85	3.40	7.20	0.67
	(1.10)	(3.42)	(2.44)	(3.24)	(5.97)	(2.58)
Past feeling	0.05	1.19	2.15	4.67	5.73	0.74
	(0.17)	(1.94)	(2.11)	(3.41)	(4.69)	(2.86)
Conflict	0.46	2.99	3.30	10.15	11.48	15.39
	(0.39)	(4.78)	(2.02)	(5.68)	(6.78)	(16.26)

A one-way ANOVA for the percentage of therapist statements containing explicit references about parents showed an overall significant effect of the type of therapy (F (5, 82) = 5.387, p<0.001). A priori contrasts showed a significantly higher percentage of therapist statements containing explicit references to parents in the Psychodynamic psychotherapy group than in the Behaviour (t (82) = 3.801, p<0.001), Cognitive-behaviour (t (82) = 3.202, p<0.005) and Cognitive (t (82) = 3.096, p<0.005) therapy groups.

A one-way ANOVA for the rate of references to parents also showed an overall significant effect of type of therapy ($F(5, 82) = 4.575$, $p<0.001$). A priori contrasts showed a significantly higher percentage of therapist statements containing explicit references to parents in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.366$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.036$, $p<0.005$) and Cognitive ($t(82) = 3.038$, $p<0.005$) therapy groups.

A one-way ANOVA for the percentage of therapist statements containing references about current thoughts and feelings showed an overall significant effect of the type of therapy ($F(5, 82) = 24.750$, $p<0.001$). Further analyses showed a significantly higher percentage of therapist statements containing such references in the Psychoanalytic, Psychodynamic and Conversational psychotherapy groups than in the Behaviour (Scheffe tests, $p<0.001$, $p<0.001$ and $p<0.001$ respectively) and Cognitive (Scheffe test, $p<0.05$, $p<0.001$ and $p<0.005$ respectively) therapy groups. The Behaviour therapy group as well as showing a significantly lower percentage than the Psychodynamic and Conversational groups also did so compared to all other groups i.e. the Cognitive-behavioural (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p< 0.05$) and Psychoanalytic (Scheffe test, $p<0.001$) groups.

A one-way ANOVA for the rate of references to current feelings and thoughts also showed an overall significant effect of type of therapy ($F(5, 82) = 40.117$, $p<0.001$). Further analyses showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.001$) therapy groups. The Psychodynamic psychotherapy group showed a significantly higher rate of references to current feelings and thoughts than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$) and Cognitive (Scheffe test, $p<0.001$) groups. The Conversational psychotherapy group showed a significantly higher rate of references than the Behaviour therapy group (Scheffe test, $p<0.005$).

There was no overall significant effect of type of therapy on the percentage of therapists' statements containing explicit references to childhood feelings, although a one-way ANOVA did show the effect to approach significance ($F(5, 82) =2.237$, $p<0.058$).

A one-way ANOVA for the rate of explicit references by therapists to childhood feelings showed an overall significant effect of type of therapy ($F(5, 82)=2.636$, $p<0.05$). A priori contrasts showed

the Psychodynamic psychotherapy group to contain a higher percentage of therapist statements with explicit references to childhood feelings than did the Behaviour ($t(82) = 2.235$, $p<0.05$), Cognitive-behaviour ($t(82) = 2.436$, $p<0.05$) and Cognitive ($t(82) = 2.102$, $p<0.05$) therapy groups.

A one-way ANOVA for the percentage of therapist statements containing explicit references about conflict showed an overall significant effect of the type of therapy ($F(5, 82) = 6.449$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such references in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 5.090$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.606$, $p<0.001$), Cognitive ($t(82) = 3.633$, $p<0.001$) and Conversational ($t(82) = 2.262$, $p<0.05$) therapy groups. A series of further a priori contrasts showed a significantly higher percentage of statements containing such references also occurred in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.234$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.586$, $p<0.05$) and Cognitive ($t(82) = 2.616$, $p<0.05$) therapy groups.

Table 5.17. The rate at which each of the 10 transference components was identified by therapists across the two therapy groupings (standard deviation in brackets).

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent				
Therapist Explicit Reference to:				
Therapist	0.009	(0.008)	0.146	(0.102)
Parent	0.004	(0.007)	0.070	(0.089)
Current feeling	0.180	(0.044)	0.477	(0.141)
Past feeling	0.001	(0.003)	0.024	(0.039)
Conflict	0.008	(0.011)	0.073	(0.070)
Therapist Implicit Reference to:				
Therapist	0.016	(0.019)	0.043	(0.064)
Parent	0.003	(0.007)	0.017	(0.030)
Current feeling	0.011	(0.011)	0.025	(0.031)
Past feeling	0.004	(0.007)	0.021	(0.023)
Conflict	0.007	(0.007)	0.074	(0.077)

Table 5.18. The rate at which each of the 10 transference components was identified by therapists across the six therapy groups (standard deviation in brackets).

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Referent						
Therapist Explicit Reference to:						
Therapist	0.008	0.008	0.019	0.066	0.144	0.204
	(0.008)	(0.004)	(0.011)	(0.049)	(0.062)	(0.152)
Parent	0.002	0.005	0.005	0.025	0.083	0.073
	(0.004)	(0.010)	(0.006)	(0.028)	(0.080)	(0.123)
Current feeling	0.165	0.197	0.182	0.361	0.465	0.580
	(0.032)	(0.056)	(0.040)	(0.059)	(0.107)	(0.174)
Past feeling	0.001	0.001	0.003	0.012	0.024	0.031
	(0.001)	(0.001)	(0.004)	(0.013)	(0.034)	(0.056)
Conflict	0.001	0.012	0.012	0.036	0.063	0.118
	(0.001)	(0.016)	(0.007)	(0.032)	(0.039)	(0.109)
Therapist Implicit reference to:						
Therapist	0.001	0.026	0.090	0.055	0.031	0.062
	(0.002)	(0.026)	(0.024)	(0.027)	(0.022)	(0.117)
Parent	0.000	0.004	0.011	0.014	0.019	0.013
	(0.000)	(0.011)	(0.010)	(0.020)	(0.017)	(0.052)
Current feeling	0.006	0.017	0.021	0.014	0.038	0.006
	(0.007)	(0.015)	(0.016)	(0.013)	(0.033)	(0.022)
Past feeling	0.001	0.005	0.015	0.019	0.028	0.007
	(0.001)	(0.011)	(0.011)	(0.014)	(0.022)	(0.026)
Conflict	0.003	0.007	0.044	0.044	0.060	0.123
	(0.003)	(0.008)	(0.018)	(0.026)	(0.034)	(0.130)

A one-way ANOVA for the rate of references about conflict also showed an overall significant effect of type of therapy ($F(5, 82) = 9.909$, $p<0.001$). Further analyses showed a significantly higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$) and Conversational (Scheffe test, $p<0.05$) therapy groups. The Psychodynamic psychotherapy group showed a significantly higher rate of references about conflict than in the Behaviour therapy group (Scheffe test, $p<0.05$).

No other analyses of therapists' explicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Explicit references by therapists

Support was obtained for the hypothesis that explicit references to all transference components would occur in all therapies.

Support was obtained for the hypothesis that explicit references would be higher in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping.

Support was not obtained for the hypothesis that there would be no significant difference in explicit references to current feelings across the Psychodynamic and Cognitive-behaviour grouping of therapies. Explicit references to current feelings were higher in the Psychodynamic grouping of therapies.

Support was obtained for the hypothesis that explicit references about the therapist would be higher in the Psychoanalytic and Psychodynamic psychotherapy groups than in the other groups.

Support was obtained for the hypothesis that explicit references about conflict would occur more in the Psychoanalytic and Psychodynamic groups than in all other groups. The one exception to this was that the references did not occur more in the Psychodynamic group than the Conversational group.

Support was obtained for the hypothesis that explicit references about parents would be higher in the Psychodynamic group than in the Behaviour, Cognitive-behaviour and Cognitive groups.

Some support was obtained for the hypothesis that explicit references about childhood feelings would be higher in the Psychodynamic group than in the Behaviour, Cognitive-behaviour and Cognitive groups.

Explicit references to current feelings and thoughts tended to be higher in the Psychoanalytic and Psychodynamic therapy groups than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups and higher in the Conversational therapy group than the Behaviour and Cognitive therapy groups.

Explicit references to current feelings and thoughts were lower in the Behaviour therapy group than in the other five therapy groups.

ii) Implicit References by Therapists

This section of analyses includes testing of the hypotheses that:

i) implicit therapist references to all transference components will occur in all therapies.

ii) implicit therapist references to childhood feelings and conflict will occur more in the Psychoanalytic and Psychodynamic psychotherapy groups than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the percentage of therapist statements containing implicit references to transference components across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher percentage of statements than Cognitive-behaviour therapies containing references to parents ($t(86) = 3.028$, $p<0.005$), childhood feelings ($t(86) = 3.748$, $p<0.001$) and conflict ($t(86) = 5.580$, $p<0.001$).

Independent Samples t-Tests were also used to compare the rate of therapist implicit references across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of references than did Cognitive-behaviour therapies to childhood feelings ($t(86) = 4.036$, $p<0.001$) and conflict ($t(86) = 4.911$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for the percentage of therapist statements containing implicit references about the therapist showed an overall significant effect of the type of therapy ($F(5,82)= 4.334$, $p<0.005$). Further analyses showed a significantly higher percentage of statements containing such references in the Conversational therapy group than in the Behaviour therapy group (Scheffe test, $p<0.005$).

A one-way ANOVA for the percentage of therapist statements containing implicit references to current thoughts and feelings showed an overall significant effect of the type of therapy ($F(5, 82) = 4.662$, $p<0.001$). Further analyses did not show any significant differences between any two groups.

A one-way ANOVA for the rate of implicit references about current feelings and thoughts also showed an overall significant effect of type of therapy ($F(5, 82) = 6.414$, $p<0.001$). Further analyses showed the Psychodynamic psychotherapy group to contain a significantly higher rate of

such references than the Behaviour (Scheffe test, $p<0.01$) and the Psychoanalytic (Scheffe test, $p<0.005$) therapy groups.

A one-way ANOVA for the percentage of therapist statements containing implicit references to childhood feelings showed an overall significant effect of type of therapy ($F(5, 82) = 8.176$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of statements containing references to childhood feelings than did the Behaviour ($t(82) = 4.898$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.660$, $p<0.001$) and Cognitive ($t(82) = 2.886$, $p<0.005$). Further analyses also showed a significantly higher percentage of statements containing such references in the Psychodynamic psychotherapy group than in the Psychoanalytic psychotherapy group (Scheffe test, $p<0.005$).

A one-way ANOVA for the rate of references about childhood feelings and thoughts also showed an overall significant effect of type of therapy ($F(5, 82) = 6.788$, $p<0.001$). A priori contrasts showed a significantly higher rate of such references were made in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.872$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.658$, $p<0.001$) and Cognitive ($t(82) = 2.941$, $p<0.005$) therapy groups.

A further one-way ANOVA for the percentage of therapist statements containing implicit references about conflict showed an overall significant effect of type of therapy ($F(5, 82) = 6.831$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a significantly higher percentage of statements containing such references than the Behaviour therapy group ($t(82) = 3.917$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.821$, $p<0.01$) and Cognitive ($t(82) = 2.718$, $p<0.01$). A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to also contain a significantly higher percentage of statements containing such references than the Behaviour ($t(82) = 4.657$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.669$, $p<0.001$) and Cognitive ($t(82) = 3.577$, $p<0.001$) therapy groups.

A one-way ANOVA for the rate of references about conflict also showed an overall significant effect of type of therapy ($F(5, 82) = 8.419$, $p<0.001$). A priori contrasts showed a significantly higher rate of such references were made in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.970$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.868$, $p<0.005$) and Cognitive ($t(82) = 2.759$, $p<0.01$) therapy groups. A further series of a priori contrasts showed a significantly higher rate of such references were also made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 4.571$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.585$, $p<0.001$) and Cognitive ($t(82) = 3.488$, $p<0.001$) therapy groups.

No other analyses of therapists' implicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Implicit references by therapists

Support was obtained for the hypothesis that implicit references to all transference components would occur in all therapies.

Support was obtained for the hypothesis that implicit references to conflict would occur more in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was obtained for the hypothesis that implicit references to conflict would occur more in the Psychodynamic psychotherapy group than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was obtained for the hypothesis that implicit references to past feelings would occur in the Psychodynamic psychotherapy group than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Implicit references to childhood feelings and conflict were higher in the Psychodynamic grouping of therapies than in the Cognitive-behaviour.

There was some evidence that implicit references to parents were higher in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping.

Implicit references to current feelings and thoughts were higher in the Psychodynamic psychotherapy group than in the Behaviour therapy group.

5.3.3 Patient Statements - Summated Transference Components

The number of different types of transference component referred to in each patient statement was calculated and compared across types of therapy.

The results presented are from the analysis of two different sorts of data, first, the mean number of different types of transference components referred to in a patient statement and, second, the mean number of different transference components referred to per line of patient statements (rate).

The mean number of different transference components referred to in each patient statement is given for the two therapy groupings in Table 5.19. The respective means for each of the six therapy groups are given in Table 5.20.

The mean number of different transference components referred to per line of patient narrative (rate) is given for the two therapy groupings in Table 5.21 and for the six therapy groups in Table 5.22.

In addition in Table 5.23 the percentage of each potential summated score of explicit transference referents in patient statements is presented across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies. In Table 5.24 this information is given presented for implicit references and in Table 5.25 for explicit and implicit references combined. Table 5.26 presents the percentage of each potential summated score of explicit transference referents in patient statements across the six therapy groups, Table 5.27 this information for implicit references, and Table 5.28 this information for explicit and implicit references combined.

Analyses carried out in the pilot study and presented in Table 2.5 (see page 49) showed a significant correlation between calculations of summated references when references to conflict were included and when they were excluded. Therefore all the results presented in this section are of summated references excluding conflict only.

This section of analyses includes testing of the hypotheses that:

i) the Psychodynamic grouping of therapies will have a higher total of different transference components referred to per patient statement than the Cognitive-behaviour grouping of therapies. This higher total of references will occur across explicit, implicit and combined explicit and implicit references.

ii) the Psychoanalytic and Psychodynamic psychotherapy groups will have a higher total of different transference components referred to per patient statement than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. This higher total of references will occur across explicit, implicit and combined explicit and implicit references.

Table 5.19. The mean summated explicit and implicit references to transference components for each patient statement, excluding conflict, across the two therapy groupings (standard deviation in brackets)

Group / Referent	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient Explicit	0.748	(0.170)	1.357	(0.350)
Patient Implicit	0.240	(0.141)	0.746	(0.478)
Patient Explicit and Implicit	0.984	(0.228)	2.109	(0.727)

Table 5.20. The mean summated explicit and implicit references to transference components for each patient statement, excluding conflict, across the six therapy groups

Group / Variable		Patient Explicit	Patient Implicit	Patient Explicit. and Implicit
Behaviour	Mean	0.749	0.104	0.843
	Std. Dev.	0.194	0.047	0.199
Cog.-beh.	Mean	0.724	0.351	1.075
	Std. Dev.	0.168	0.127	0.185
Cognitive	Mean	0.772	0.292	1.061
	Std. Dev.	0.157	0.092	0.232
Conversat.	Mean	1.059	0.604	1.660
	Std. Dev.	0.130	0.208	0.284
P'dynamic	Mean	1.257	0.556	1.812
	Std. Dev.	0.206	0.273	0.434
P'analytic	Mean	1.762	1.231	2.991
	Std. Dev.	0.342	0.602	0.667
Total possible score		4	4	8

i) Explicit Patient References

The Two Therapy Groupings

An Independent Samples t-Test was used to compare the mean number of different transference components explicitly referred to in patient statements across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This showed Psychodynamic therapies to contain a

significantly higher mean number per statement than did Cognitive-behaviour therapies (t (86) = 9.225, p<0.001).

An Independent Samples t-Test was also used to compare the mean number of different transference components explicitly referred to per line of patient statements (rate) across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This test showed Psychodynamic therapies to contain a significantly lower rate of references than did Cognitive-behaviour therapies (t (86) = 6.610, p<0.001).

Table 5.21. The rate of summated explicit and implicit references to transference components for each patient statement, excluding conflict, across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent				
Patient Explicit	0.343	(0.119)	0.206	(0.075)
Patient Implicit	0.098	(0.046)	0.102	(0.049)
Patient Explicit and Implicit	0.439	(0.127)	0.308	(0.100)

Table 5.22. The rate of summated explicit and implicit references to transference components for each patient statement, excluding conflict, across the six therapy groups

Group		Patient Explicit	Patient Implicit	Patient Explicit. and Implicit
Variable				
Behaviour	Mean	0.430	0.062	0.489
	Std. Dev.	0.094	0.030	0.113
Cog.-beh.	Mean	0.233	0.106	0.339
	Std. Dev.	0.085	0.033	0.087
Cognitive	Mean	0.349	0.132	0.480
	Std. Dev.	0.086	0.045	0.127
Conversat.	Mean	0.206	0.106	0.312
	Std. Dev.	0.084	0.026	0.098
P'dynamic	Mean	0.200	0.080	0.279
	Std. Dev.	0.072	0.025	0.085
P'analytic	Mean	0.220	0.146	0.368
	Std. Dev.	0.080	0.067	0.110
Total possible score		4	4	8

The Six Therapy Groups

A one-way ANOVA for the mean number of different transference components explicitly referred to in patient statements across the six therapy groups showed an overall significant effect of type of therapy ($F(5, 82) = 46.41$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher mean number per statement than the Behaviour ($t(82) = 6.804$, $p<0.001$), Cognitive-behaviour ($t(82) = 6.676$, $p<0.001$) and Cognitive ($t(82) = 6.076$, $p<0.001$) therapy groups. A series of further a priori contrasts showed the Psychoanalytic psychotherapy group to also refer to a significantly higher mean number of different transference components in statements than the Behaviour ($t(82) = 11.903$, $p<0.001$), Cognitive-behaviour ($t(82) = 11.573$, $p<0.001$) and Cognitive ($t(82) = 11.038$, $p<0.001$) therapy groups. Further analyses also showed the Psychoanalytic group to refer to a significantly higher mean number of different transference components than the Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$) groups.

A one-way ANOVA was also used to compare the mean number of different transference components explicitly referred to per line of patient statements (rate) across the six therapy groups. This showed an overall significant effect of type of therapy ($F(5, 82) = 18.286$, $p<0.001$). Further analyses showed a significantly higher rate of such references were made in the Behaviour therapy group than in the Cognitive-behaviour (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.001$), Psychodynamic (Scheffe test, $p<0.001$) and the Psychoanalytic (Scheffe test, $p<0.001$) therapy groups. The Cognitive therapy group showed a significantly higher rate of such references than the Psychodynamic psychotherapy group (Scheffe test, $p<0.001$).

No other analyses of patients' explicit summated references showed any significant differences either across the two therapy groupings or the six therapy groups.

ii) Implicit Patient References

The Two Therapy Groupings

An Independent Samples t-Test was used to compare the mean number of different transference components implicitly referred to in patient statements across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This showed Psychodynamic therapies to contain a significantly higher mean number of implicit references to components per statement than did Cognitive-behaviour therapies ($t(86) = 5.832$, $P<0.001$).

The Six Therapy Groups

A one-way ANOVA for the mean number of different transference components implicitly referred to in patient statements showed an overall significant effect of type of therapy ($F(5, 82) = 21.546$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group contained a significantly higher number of summated references than the Behaviour ($t(82) = 4.276$, $p<0.001$) and Cognitive ($t(82) = 2.334$, $p<0.05$) therapy groups. A series of further a priori contrasts showed the Psychoanalytic psychotherapy group to have a significantly higher rating than the Behaviour ($t(82) = 9.355$, $p<0.001$), Cognitive-behaviour ($t(82) = 6.929$, $p<0.001$) and Cognitive ($t(82) = 7.394$, $p<0.001$) therapy groups. Further analyses showed the Psychoanalytic group to also have a higher rating than the Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$) groups and the Conversational group a higher rating than the Behaviour therapy group (Scheffe test, $p<0.005$).

A one-way ANOVA was also used to compare the mean number of different transference components implicitly referred to per line of patient statements (rate) across the six therapy groups. This showed an overall significant effect of type of therapy ($F(5, 82) = 9.503$, $p<0.001$). A priori contrasts showed the Psychoanalytic psychotherapy group to have a significantly higher rate of such references than the Behaviour ($t(82) = 5.536$, $p<0.001$) and the Cognitive-behaviour ($t(82) = 2.482$, $p<0.05$) therapy groups. Further analyses showed the Psychoanalytic psychotherapy group to also have a higher rate of references than the Psychodynamic psychotherapy group (Scheffe test, $p<0.001$) and the Cognitive therapy group a higher rate than the Behaviour therapy group (Scheffe test, $p<0.01$).

No other analyses of patients' implicit summated references showed any significant differences either across the two therapy groupings or the six therapy groups.

iii) Combined Explicit and Implicit Patient References

The Two Therapy Groupings

An Independent Samples t-Test was used to compare the mean number of different transference components explicitly and implicitly referred to in patient statements across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This showed Psychodynamic therapies to contain a significantly higher mean number of references to components per statement than did Cognitive-behaviour therapies ($t(86) = 8.446$, $P<0.001$).

An Independent Samples t-Test was also used to compare the mean number of different transference components explicitly and implicitly referred to per line of patient statements (rate)

across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This test showed Psychodynamic therapies to contain a significantly lower rate of references than did Cognitive-behaviour therapies ($t(86) = 5.010$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for the mean total number of explicit and implicit references to transference components in patient statements showed an overall significant effect of type of therapy ($F(5, 82) = 50.022$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group contained a higher number of summated references than the Behaviour ($t(82) = 6.937$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.935$, $p<0.001$) and Cognitive ($t(82) = 5.028$, $p<0.05$) therapy groups. A series of further a priori contrasts showed the Psychoanalytic psychotherapy group to have a significantly higher rating than the Behaviour ($t(82) = 13.500$, $p<0.001$), Cognitive-behaviour ($t(82) = 11.426$, $p<0.001$) and Cognitive ($t(82) = 11.509$, $p<0.001$) therapy groups. Further analyses showed the Psychoanalytic group to also have a higher rating than the Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$) groups and the Conversational group a higher rating than the Behaviour therapy group (Scheffe test, $p<0.005$).

Table 5.23. Percentage of each potential summated score of explicit transference referents in patient statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
No.of Referents				
0	32.48	(13.05)	14.66	(10.00)
1	60.91	(12.10)	45.32	(16.35)
2	5.88	(4.69)	31.73	(18.29)
3	0.70	(1.41)	6.24	(9.30)
4	0.01	(0.07)	2.06	(6.59)

A one-way ANOVA was also used to compare the mean number of different transference components explicitly and implicitly referred to per line of patient statements (rate) across the six therapy groups. This showed an overall significant effect of type of therapy ($F(5, 82) = 11.441$, $p<0.001$). Further analyses showed a significantly higher rate of such references were made in the Behaviour therapy group than in the Conversational (Scheffe test, $p<0.01$) and the Psychodynamic

(Scheffe test, $p<0.001$) therapy groups. The Cognitive therapy group showed a significantly higher rate of such references than the Psychodynamic psychotherapy group (Scheffe test, $p<0.001$).

No other analyses of patients' combined explicit and implicit summated references showed any significant differences either across the two therapy groupings or the six therapy groups.

Table 5.24. Percentage of each potential summated score of implicit transference referents in patient statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
No. of Referents				
0	82.05	(10.31)	57.90	(20.06)
1	12.98	(8.01)	21.51	(16.33)
2	3.96	(2.58)	11.54	(10.70)
3	0.92	(1.28)	6.66	(10.43)
4	0.10	(0.30)	2.40	(6.48)

Table 5.25. Percentage of each potential summated score of combined explicit and implicit transference referents in patient statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
No.of Referents				
0	32.10	(12.81)	14.43	(9.91)
1	45.94	(15.58)	25.59	(12.54)
2	15.36	(8.86)	26.81	(12.23)
3	5.15	(3.43)	15.61	(11.24)
4	1.19	(1.60)	9.26	(9.32)
5	0.20	(0.42)	5.92	(11.01)
6	0.06	(0.25)	0.96	(2.27)
7	0.00	(0.00)	0.65	(3.40)
8	0.00	(0.00)	0.60	(4.45)

Table 5.26. Percentage of each potential summated score of explicit transference referents in patient statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
No.of Referents						
0	31.05	34.87	31.81	20.49	18.36	3.14
	(13.57)	(14.69)	(11.69)	(6.86)	(6.72)	(8.32)
1	63.90	58.30	59.94	56.29	43.71	41.33
	(11.87)	(13.96)	(10.80)	(12.30)	(12.03)	(23.12)
2	4.12	6.37	7.52	20.20	32.51	37.79
	(4.82)	(3.29)	(5.40)	(9.01)	(11.61)	(28.95)
3	0.92	0.45	0.69	2.81	4.75	11.60
	(2.02)	(0.84)	(1.04)	(2.39)	(5.20)	(15.30)
4	0.00	0.00	0.04	0.19	0.69	6.14
	(0.00)	(0.00)	(0.13)	(0.60)	(1.43)	(11.90)

Table 5.27. Percentage of each potential summated score of implicit transference referents in patient statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
No.of Referents						
0	92.10	74.69	77.35	61.78	66.77	36.99
	(3.53)	(9.90)	(5.77)	(9.65)	(12.92)	(22.59)
1	5.45	17.91	17.08	22.48	18.68	26.71
	(2.89)	(8.66)	(3.84)	(7.63)	(7.68)	(28.92)
2	2.47	5.03	4.67	10.25	8.50	18.67
	(1.73)	(2.50)	(2.85)	(6.37)	(5.22)	(17.00)
3	0.00	2.18	0.77	4.48	5.08	11.40
	(0.00)	(1.43)	(0.83)	(2.43)	(4.86)	(18.43)
4	0.00	0.19	0.14	1.02	0.99	6.22
	(0.00)	(0.31)	(0.44)	(1.98)	(1.79)	(11.58)

Table 5.28. Percentage of each potential summated score of combined explicit and implicit transference referents in patient statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
No.of Referents						
0	31.35	34.52	30.57	20.55	18.28	2.41
	(13.71)	(14.11)	(11.21)	(6.71)	(6.67)	(6.87)
1	57.03	37.06	41.53	30.59	27.81	17.67
	(10.13)	(18.17)	(10.36)	(10.50)	(10.45)	(14.72)
2	7.85	19.13	20.61	25.68	27.96	25.18
	(4.08)	(9.79)	(5.68)	(9.35)	(9.00)	(18.75)
3	3.73	5.89	6.12	12.38	13.37	22.40
	(2.67)	(3.24)	(4.12)	(6.14)	(7.24)	(17.07)
4	0.04	2.77	0.98	7.63	8.24	12.47
	(0.10)	(1.92)	(0.76)	(5.00)	(5.28)	(15.81)
5	0.00	0.44	0.19	2.61	2.90	14.36
	(0.00)	(0.52)	(0.45)	(3.70)	(3.83)	(18.21)
6	0.00	0.20	0.00	0.58	1.09	0.95
	(0.00)	(0.43)	(0.00)	(0.99)	(1.64)	(3.69)
7	0.00	0.00	0.00	0.00	0.37	1.67
	(0.00)	(0.00)	(0.00)	(0.00)	(0.99)	(6.46)
8	0.00	0.00	0.00	0.00	0.00	0.22
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(8.60)

Summary

Summated transference components in patient statements

Support was obtained for the hypotheses that the Psychodynamic grouping of therapies would have a higher total of different transference components referred to explicitly, implicitly, and explicitly and implicitly combined, in patient statements than the Cognitive-behavioural grouping.

Support was obtained for the hypotheses that the Psychoanalytic psychotherapy group would have a higher total of different transference components referred to explicitly, implicitly, and explicitly and implicitly combined, in patient statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. It also had a higher total than the Conversational and Psychodynamic groups.

Support was also obtained for the hypotheses that the Psychodynamic psychotherapy group would have a higher total of different transference components referred to explicitly, and explicitly and implicitly combined, in patient statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Partial support was obtained for the hypothesis that the Psychodynamic psychotherapy group would have a higher total of different transference components implicitly referred to in patient statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In fact it had a higher total than the Behaviour and Cognitive therapy groups.

In contrast to the summated transference components per patient statement detailed above analysis of the total of different transference components referred to per line of patient statements produced markedly different findings:
i) the Cognitive-behaviour grouping of therapies had a higher total of explicit, and explicit and implicit combined, references than the Psychodynamic grouping
ii) the Behaviour therapy group had a higher explicit total than other groups and the Cognitive a higher total than the Psychodynamic
iii) the Cognitive therapy group had a higher implicit total than the Behaviour group and the Psychoanalytic group a higher implicit total than the Behaviour, Cognitive-behaviour and Psychodynamic groups.

5.3.4 Therapist Statements - Summated Transference Components

The number of different types of transference components referred to in each therapist statement was calculated and compared across types of therapy.

As with the analysis of summated transference components in patient statements reported above the results presented below analysed two different sorts of data, first, the mean number of different types of transference components referred to in a patient statement and, second, the mean number of different transference components referred to per line of patient statements (rate).

The mean number of different transference components referred to in each therapist statement is given for the two therapy groupings in Table 5.29. The respective means for each of the six therapy groups is given in Table 5.30.

The mean number of different transference components referred to per line of therapist narrative (rate) is given for the two therapy groupings in Table 5.31 and for the six therapy groups in Table 5.32.

The percentage of each potential summated score of transference referents in therapist statements across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies is presented for explicit references in Table 5.33, for implicit references in Table 5.34 and for combined explicit and implicit references in Table 5.35. The percentage of each potential summated score of transference referents in therapist statements across the six therapy groups is presented for explicit references in Table 5.36, for implicit references in Table 5.37 and for combined explicit and implicit references in Table 5.38.

As in the previous section, all the results presented in this section are of summated references excluding conflict only.

This section of analyses includes testing of the hypotheses that:

i) the Psychodynamic grouping of therapies will have a higher total of different transference components referred to per therapist statement than the Cognitive-behaviour grouping of therapies. This higher total of references will occur across explicit, implicit and combined explicit and implicit references.

ii) the Psychoanalytic and Psychodynamic psychotherapy groups will have a higher total of different transference components referred to per therapist statement than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. This higher total of references will occur across explicit, implicit and combined explicit and implicit references.

Table 5.29. The mean summated explicit and implicit references to transference components for each therapist statement, excluding conflict, across the two therapy groupings (standard deviation in brackets)

Group Referent	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Therapist Explicit	0.435	(0.173)	1.032	(0.236)
Therapist Implicit	0.097	(0.087)	0.192	(0.136)
Therapist Explicit and Implicit	0.527	(0.248)	1.233	(0.287)

Table 5.30. The mean summated explicit and implicit references to transference components for each therapist statement, excluding conflict, across the six therapy groups (standard deviation in brackets)

Group / Variable		Therapist Explicit	Therapist Implicit	Therapist Explicit and Implicit
Behaviour	Mean	0.246	0.018	0.254
	Std. Dev.	0.066	0.026	0.068
Cog.-beh.	Mean	0.551	0.140	0.685
	Std. Dev	0.105	0.100	0.175
Cognitive	Mean	0.546	0.151	0.697
	Std. Dev.	0.101	0.043	0.130
Conversat.	Mean	0.919	0.239	1.160
	Std. Dev.	0.164	0.095	0.219
P'dynamic	Mean	1.072	0.225	1.299
	Std. Dev.	0.201	0.106	0.264
P'analytic	Mean	1.025	0.094	1.145
	Std. Dev.	0.319	0.169	0.350
Total possible score		4	4	8

Table 5.31. The rate of summated explicit and implicit references to transference components for each therapist statement, excluding conflict, across the two therapy groupings (standard deviation in brackets)

Group / Referent	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Therapist Explicit	0.175	(0.042)	0.602	(0.226)
Therapist Implicit	0.034	(0.028)	0.103	(0.090)
Therapist Explicit and Implicit	0.206	(0.582)	0.711	(0.256)

Table 5.32. The rate of summated explicit and implicit references to transference components for each therapist statement, excluding conflict, across the six therapy groups

Group Variable		Therapist Explicit	Therapist Implicit	Therapist Explicit. and Implicit
Behaviour	Mean	0.168	0.013	0.174
	Std. Dev.	0.032	0.021	0.081
Cog.-beh.	Mean	0.182	0.044	0.224
	Std. Dev.	0.062	0.033	0.084
Cognitive	Mean	0.077	0.049	0.226
	Std. Dev.	0.028	0.012	0.084
Conversat.	Mean	0.385	0.095	0.481
	Std. Dev.	0.092	0.023	0.090
P'dynamic	Mean	0.562	0.112	0.675
	Std. Dev.	0.108	0.041	0.106
P'analytic	Mean	0.828	0.088	0.940
	Std. Dev.	0.282	0.166	0.363
Total possible score		4	4	8

i) Explicit Therapist References

The Two Therapy Groupings

An Independent Samples t-Test was used to compare the mean number of different transference components explicitly referred to in therapist statements across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This showed Psychodynamic therapies to contain a significantly higher mean number of explicit references to components per statement than did Cognitive-behaviour therapies ($t(80.622) = 13.614$, $p<0.001$).

An Independent Samples t-Test was also used to compare the mean number of different transference components explicitly referred to per line of therapist statements (rate) across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This test showed Psychodynamic therapies to contain a significantly higher rate of references than did Cognitive-behaviour therapies ($t(86) = 10.523$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for the mean number of different explicit references to transference components in therapist statements showed an overall significant effect of type of therapy ($F(5, 82) = 42.794$, $p<0.001$). A priori contrasts showed the Psychoanalytic psychotherapy group to

have a significantly higher rating than the Behaviour (t (82) = 10.324, p<0.001), Cognitive-behaviour (t (82) = 5.960, p<0.001) and Cognitive (t (82) = 6.023, p<0.001) therapy groups. A series of further a priori contrasts also showed the Psychodynamic psychotherapy group to have a significantly higher rating than the Behaviour (t (82) = 12.469, p<0.001), Cognitive-behaviour (t (82) = 7.352, p<0.001) and Cognitive (t (82) = 7.423, p<0.001) therapy groups. Further analyses showed the Conversational psychotherapy group to also have significantly higher ratings than the Behaviour, Cognitive-behaviour and Cognitive therapy groups (Scheffe tests, p<0.001, p<0.01 and p<0.005 respectively).

A one-way ANOVA was also used to compare the mean number of different transference components explicitly referred to per line of therapist statements (rate) across the six therapy groups. This showed an overall significant effect of type of therapy (F (5, 82) = 51.570, p<0.001). A priori contrasts showed the Psychodynamic psychotherapy group to have a significantly higher rate of references than the Behaviour (t (82) = 8.326, p<0.001), Cognitive-behaviour (t (82) = 7.511, p<0.001) and Cognitive (t (82) = 7.606, p<0.001) therapy groups. A series of further a priori contrasts also showed the Psychoanalytic psychotherapy group to contain a significantly higher rate of such references than the Behaviour (t (82) = 12.249, p<0.001), Cognitive-behaviour (t (82) = 11.377, p<0.001) and Cognitive (t (82) = 11.462, p<0.001) therapy groups. Further analyses showed the Psychoanalytic psychotherapy group to also have a higher rate of references than the Conversational (Scheffe test, p<0.001) and the Psychodynamic (Scheffe test, p<0.001) therapy groups.

No other analyses of therapists' explicit summated references showed any significant differences either across the two therapy groupings or the six therapy groups.

ii) Implicit Therapist References

The Two Therapy Groupings

An Independent Samples t-Test was used to compare the mean number of different transference components implicitly referred to in therapist statements across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This showed Psychodynamic therapies to contain a significantly higher mean number of implicit references to components per statement than did Cognitive-behaviour therapies (t (86) = 3.558, p<0.001).

An Independent Samples t-Test was also used to compare the mean number of different transference components implicitly referred to per line of therapist statements (rate) across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This test showed

Psychodynamic therapies to contain a significantly higher rate of references than did Cognitive-behaviour therapies ($t(86) = 4.178$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for the mean number of different implicit references to transference components in therapist statements showed an overall significant effect of type of therapy ($F(5, 82) = 8.958$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to have significantly higher ratings than the Behaviour ($t(82) = 5.735$, $p<0.001$) and Cognitive-behaviour ($t(82) = 2.210$, $p<0.05$) therapy groups. Further analyses showed the Conversational psychotherapy group to have significantly higher ratings than the Behaviour therapy group (Scheffe test, $p<0.001$) and the Psychodynamic psychotherapy group higher than the Psychoanalytic (Scheffe test, $p<0.05$).

A one-way ANOVA was also used to compare the mean number of different transference components implicitly referred to per line of therapist statements (rate) across the six therapy groups. This showed an overall significant effect of type of therapy ($F(5, 82) = 4.000$, $p<0.005$). A priori contrasts showed the Psychodynamic psychotherapy group to have a significantly higher rate of such references than the Behaviour ($t(82) = 3.918$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.505$, $p<0.05$) and Cognitive ($t(82) = 2.339$, $p<0.05$) therapy groups and the Psychoanalytic psychotherapy group a higher rate than the Behaviour therapy group ($t(82) = 2.580$, $p<0.05$).

No other analyses of therapists' implicit summated references showed any significant differences either across the two therapy groupings or the six therapy groups.

vi) Combined Explicit and Implicit Therapist References

The Two Therapy Groupings

An Independent Samples t-Test was used to compare the mean number of different transference components explicitly and implicitly referred to in therapist statements across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This showed Psychodynamic therapies to contain a significantly higher mean number of implicit references to components per statement than did Cognitive-behaviour therapies ($t(72.951) = 12.107$, $p<0.001$).

An Independent Samples t-Test was also used to compare the mean number of different transference components explicitly and implicitly referred to per line of therapist statements (rate) across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. This test showed

Psychodynamic therapies to contain a significantly higher rate of references than did Cognitive-behaviour therapies ($t(86) = 10.979$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for the mean total number of explicit and implicit references to transference components in therapist statements showed an overall significant effect of type of therapy ($F(5, 82) = 41.393$, $p<0.001$). A priori contrasts showed the Psychoanalytic psychotherapy group to have a significantly higher number of references than the Behaviour ($t(82) = 9.600$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.701$, $p<0.001$) and Cognitive ($t(82) = 4.579$, $p<0.001$) therapy groups. A series of further a priori contrasts also showed the Psychodynamic psychotherapy group to have a significantly higher number of references than the Behaviour ($t(82) = 12.828$, $p<0.001$), Cognitive-behaviour ($t(82) = 7.046$, $p<0.001$) and Cognitive ($t(82) = 6.908$, $p<0.001$) therapy groups. Further analyses showed the Conversational psychotherapy group to also have a significantly higher number of references than the Behaviour, Cognitive-behaviour and Cognitive therapy groups (Scheffe tests, $p<0.001$, $p<0.001$ and $p<0.005$ respectively) and the Cognitive and Cognitive-behaviour therapy groups a higher number of references than the Behaviour therapy group (Scheffe tests, $p<0.005$ and $p<0.01$ respectively).

Table 5.33. Percentage of each potential summated score of explicit transference referents in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
No.of Referents				
0	59.18	(15.50)	27.48	(11.10)
1	38.30	(14.36)	45.09	(14.55)
2	2.44	(2.94)	24.52	(15.06)
3	0.08	(0.30)	2.64	(5.31)
4	0.00	(0.00)	0.31	(0.92)

A one-way ANOVA was also used to compare the mean number of different transference components explicitly and implicitly referred to per line of therapist statements (rate) across the six therapy groups. This showed an overall significant effect of type of therapy ($F(5, 82) = 46.161$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to have a significantly higher rate of references than the Behaviour ($t(82) = 8.734$, $p<0.001$), Cognitive-behaviour ($t(82) = 7.341$, $p<0.001$) and Cognitive ($t(82) = 7.314$, $p<0.001$) therapy groups. A

series of further a priori contrasts showed the Psychoanalytic psychotherapy group to also have a significantly higher rate of such references than the Behaviour ($t(82) = 11.718$, $p<0.001$), Cognitive-behaviour ($t(82) = 10.383$, $p<0.001$) and Cognitive ($t(82) = 10.359$, $p<0.001$) therapy groups. Further analyses showed the Psychoanalytic group to also have a higher rate than the Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$) groups and the Conversational group a higher rate than the Behaviour (Scheffe test, $p<0.005$) group.

No other analyses of therapists' combined explicit and implicit summated references showed any significant differences either across the two therapy groupings or the six therapy groups.

Table 5.34. Percentage of each potential summated score of implicit transference referents in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
No.of Referents				
0	87.31	(19.03)	82.86	(15.30)
1	7.06	(6.74)	13.00	(10.38)
2	0.81	(1.47)	3.22	(4.72)
3	0.28	(0.70)	0.90	(3.47)
4	0.00	(0.00)	0.04	(0.32)

Table 5.35. Percentage of each potential summated score of combined explicit and implicit transference referents in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
No.of Referents				
0	56.88	(16.70)	23.53	(11.97)
1	35.31	(11.90)	37.38	(15.87)
2	6.49	(6.25)	29.68	(15.24)
3	0.91	(1.46)	5.76	(6.38)
4	0.41	(0.79)	1.54	(2.07)
5	0.02	(0.09)	0.24	(0.73)
6	0.00	(0.00)	0.07	(0.41)
7	0.00	(0.00)	0.00	(0.00)
8	0.00	(0.00)	0.00	(0.00)

Table 5.36. Percentage of each potential summated score of explicit transference referents in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
No.of Referents						
0	76.00	47.89	50.29	27.98	24.85	32.58
	(6.68)	(9.99)	(8.17)	(10.31)	(10.76)	(11.16)
1	23.43	49.16	45.29	53.48	47.42	34.53
	(6.82)	(9.70)	(8.89)	(9.75)	(10.05)	(19.31)
2	0.58	2.94	4.18	17.44	23.83	30.66
	(0.57)	(1.31)	(4.41)	(8.25)	(8.72)	(24.64)
3	0.00	0.00	0.25	0.76	3.45	2.22
	(0.00)	(0.00)	(0.51)	(1.33)	(3.83)	(8.60)
4	0.00	0.00	0.00	0.32	0.46	0.00
	(0.00)	(0.00)	(0.00)	(0.68)	(1.16)	(0.00)

Table 5.37. Percentage of each potential summated score of implicit transference referents in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
No.of Referents						
0	90.59	82.80	87.79	80.47	81.79	84.47
	(28.55)	(14.40)	(2.66)	(6.64)	(8.56)	(16.78)
1	1.08	11.43	9.86	15.99	14.79	10.84
	(1.03)	(8.50)	(2.28)	(5.55)	(8.24)	(9.62)
2	0.00	0.66	1.92	2.71	2.81	2.34
	(0.00)	(1.08)	(2.00)	(2.37)	(2.53)	(4.03)
3	0.00	0.44	0.44	0.83	0.54	0.69
	(0.00)	(0.93)	(0.80)	(1.60)	(1.20)	(2.81)
4	0.00	0.00	0.00	0.00	0.08	0.03
	(0.00)	(0.00)	(0.00)	(0.00)	(0.43)	(0.26)

Table 5.38. Percentage of each potential summated score of combined explicit and implicit transference referents in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
No.of Referents						
0	75.41	44.80	46.72	25.67	20.75	27.84
	(6.94)	(9.61)	(8.64)	(9.87)	(10.59)	(14.81)
1	23.83	44.10	40.28	41.63	41.56	25.91
	(7.09)	(6.59)	(9.70)	(9.73)	(11.93)	(20.76)
2	0.77	9.32	10.53	26.08	28.13	35.28
	(0.68)	(6.34)	(4.80)	(8.89	(10.25)	(24.01)
3	0.00	1.18	1.73	4.65	6.84	4.29
	(0.00)	(1.33)	(1.91)	(3.70)	(4.77)	(9.84)
4	0.00	0.61	0.70	1.55	2.28	0.00
	(0.00)	(1.10)	(0.76)	(1.90)	(2.24)	(0.00)
5	0.00	0.00	0.05	0.29	0.33	0.00
	(0.00)	(0.00)	(0.16)	(0.62)	(0.00)	(0.00)
6	0.00	0.00	0.00	0.12	0.09	0.00
	(0.00)	(0.00)	(0.00)	(0.38)	(0.52)	(0.00)
7	0.00	0.00	0.00	0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
8	0.00	0.00	0.00	0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)

Summary

Summated transference components in therapist statements

Support was obtained for the hypothesis that the Psychodynamic grouping of therapies would have a higher total of different transference components referred to explicitly, implicitly and explicitly and implicitly combined in therapist statements, and per line of therapist statements, than the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that the Psychoanalytic and Psychodynamic psychotherapy groups would have a higher total of different transference components referred to explicitly and explicitly and implicitly combined in therapist statements, and per line of therapist statements, than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In addition the Psychoanalytic psychotherapy group also had a higher total than the Conversational and Psychodynamic psychotherapy groups.

Partial support was obtained for the hypothesis that the Psychodynamic psychotherapy group would have a higher mean total of different transference components implicitly referred to in therapist statements than would the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In fact it had a higher mean total than the Behaviour, Cognitive-behaviour and Psychoanalytic groups.

Support was obtained for the hypothesis that the Psychodynamic psychotherapy group would have a higher mean total of different transference components implicitly referred to per line of therapist statement than the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was not obtained however for the hypothesis that the Psychoanalytic psychotherapy group would have a higher total of different transference components implicitly referred to in therapist statements, and per line of therapist statements, than the Behaviour, Cognitive-behaviour and Cognitive groups. The only part of the hypothesis that found support was that the Psychoanalytic psychotherapy group would have a higher total per line of therapist statement than the Behaviour therapy group.

The Conversational psychotherapy group had a higher total of different transference components referred to explicitly and explicitly and implicitly combined, in therapist statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In addition the Cognitive and Cognitive-behaviour therapy groups had a higher total than the Behaviour therapy group.

5.3.5. Patient and Therapist Statements - Linking of Transference Components within Statements

Patient and therapist statements were analysed across the two therapy groupings and the six therapy groups to ascertain which transference components were linked together within statements and how frequently. Within the pilot study, correlational analyses had shown ratings of linked explicit components correlated significantly with combined linked explicit and implicit ratings, both when references to conflict were included and when they were excluded (see Table 2.5, page 49). The study had therefore only fully analysed explicitly linked references excluding conflict. The present study analysed the linking of transference references, considering both explicit and combined explicit and implicit references including references made to interpersonal or intrapersonal conflict.

i) Patient Statements

This section of analyses includes testing of the hypotheses that:

i) the Psychodynamic grouping of therapies will contain a higher number of patient statements than the Cognitive-behaviour grouping of therapies linking the therapist and current feeling; therapist and parent; therapist and conflict; parent and past feeling; parent and conflict; current feeling and conflict; current feeling and past feeling; therapist, current and past feeling; therapist, current feeling and conflict; parent, current feeling and past feeling; parent, past feeling and conflict; therapist, parent and current feeling; therapist, parent and past feeling; therapist, parent and current feeling; therapist, parent, current feeling and past feeling; and therapist, parent, current feeling, past feeling and conflict.

ii) the Psychodynamic psychotherapy group will contain a higher number of patient statements than other groups including the Psychoanalytic and Conversational psychotherapy groups linking therapist and parent; parent and past feeling; parent and conflict; current and past feeling; therapist, current feeling and past feeling; therapist, parent and current feeling; parent and past feeling and current feeling; parent, past feeling and conflict; therapist, parent and current feeling; therapist, parent and past feeling; therapist, parent, current feeling and past feeling; and therapist, parent, current feeling, past feeling and conflict.

iii) the Psychodynamic psychotherapy group will contain a higher number of patient statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups linking therapist and current feeling; current feeling and conflict; and therapist, current feeling and conflict

iv) the Psychoanalytic psychotherapy group will contain a higher number of patient statements than other groups including the Psychodynamic and the Conversational psychotherapy groups linking current feeling and therapist; current feeling and conflict; and current feeling, therapist and conflict

Explicit Patient Statements - The percentage of patient statements within sessions in which various explicit references to transference components were linked together was analysed. Mean percentages of each of these linked references are presented for the two therapy groupings Cognitive-behaviour (Behaviour, Cognitive-behaviour and Cognitive) and Psychodynamic (Conversational, Psychodynamic and Psychoanalytic) in Table 5.39 and for each of the six therapy groups in Table 5.40.

Table 5.39. Mean Percentage of explicit patient statements in which various transference referents are linked (standard deviation in brackets)

Group Referents Linked	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Parent and past feeling	0.89	(1.51)	5.29	(9.72)
Therapist and current feeling	3.88	(3.21)	29.31	(16.68)
Current feeling and conflict	6.01	(6.10)	20.59	(13.88)
Parent and Conflict	0.94	(1.44)	5.64	(9.67)
Current and past feeling	1.40	(2.59)	6.49	(9.68)
Therapist, current feeling and conflict	0.58	(0.97)	8.26	(9.56)
Parent, past feeling and conflict	0.31	(0.78)	2.14	(5.25)
Therapist, current and past feeling	0.01	(0.07)	2.77	(7.23)
Parent, current and past feeling	0.69	(1.34)	4.84	(9.17)
Therapist, parent and past feeling	0.01	(0.07)	2.08	(6.61)
Therapist, parent and current feeling	0.01	(0.07)	4.16	(7.47)
Therapist, parent, current and past feeling	0.01	(0.07)	2.02	(6.60)
Therapist, parent, past feeling and conflict	0.01	(0.07)	1.06	(4.82)
Therapist, parent, current and past feeling and conflict	0.01	(0.07)	1.06	(4.82)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare, across the two broad groupings of Psychodynamic and Cognitive-behaviour therapies, patients' explicit linking of transference components. These tests showed the Psychodynamic therapies grouping to contain a significantly higher percentage of statements in which links were made between: parent and past feeling ($t(86) = 2.534$, $p<0.05$), therapist and current feeling ($t(86) = 8.513$, $p<0.001$), current feeling and conflict ($t(86) = 5.631$, $p<0.001$), parent and conflict ($t(86) = 2.722$, $p<0.01$) current and past feeling ($t(86) = 2.910$, $p<0.005$), therapist, current feeling and conflict ($t(86) = 4.522$, $p<0.001$), therapist, current and past feeling ($t(86) = 2.150$, $p<0.05$), parent, current and past feeling ($t(86) = 2.534$, $p<0.05$) and therapist, parent and current feeling ($t(86)$ 3.136, $p<0.005$). The Psychodynamic therapies group also approached being significantly higher on statements linking parent, past feeling and conflict ($t(86) = 1.954$, $p<0.054$). There were no significant differences between the two groups on statements linking therapist, parent and past feeling; therapist, parent, current and past feeling; therapist, parent, past feeling and conflict; and therapist, parent, current and past feeling and conflict.

Table 5.40. Mean Percentage of explicit patient statements in which various transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Parent and past feeling	0.87	0.83	0.98	1.76	3.93	10.45
	(1.87)	(1.33)	(1.33)	(2.01)	(5.89)	(15.90)
Therapist and current feeling	1.50	4.47	6.16	16.79	27.57	41.26
	(1.31)	(1.90)	(4.01)	(12.06)	(10.42)	(22.26)
Current feeling and conflict	2.29	9.56	6.91	17.00	16.10	32.28
	(2.36)	(7.98)	(4.92)	(7.03)	(9.07)	(18.68)
Parent and Conflict	0.50	1.70	0.72	3.37	3.39	11.80
	(1.01)	(2.08)	(0.80)	(3.41)	(4.38)	(16.22)
Current and past feeling	2.10	0.55	1.41	3.58	4.33	12.90
	(3.80)	(0.84)	(1.79)	(2.94)	(6.01)	(14.98)
Therapist, current feeling and conflict	0.14	0.61	1.07	4.86	6.26	14.67
	(0.19)	(1.08)	(1.22)	(4.42)	(6.05)	(14.39)
Parent, past feeling and conflict	0.18	0.67	0.11	1.64	1.44	3.91
	(0.37)	(1.26)	(0.35)	(2.00)	(2.64)	(9.28)
Therapist, current and past feeling	0.00	0.00	0.04	0.47	0.80	8.37
	(0.00)	(0.00)	(0.13)	(1.01)	(1.84)	(12.30)
Parent, current and past feeling	0.87	0.45	0.73	1.76	3.47	9.71
	(1.87)	(0.84)	(1.05)	(2.01)	(4.80)	(15.57)
Therapist, parent and past feeling	0.00	0.00	0.04	0.19	0.72	6.13
	(0.00)	(0.00)	(0.13)	(0.60)	(1.66)	(11.90)
Therapist, parent and current feeling	0.00	0.00	0.04	1.15	2.19	10.25
	(0.00)	(0.00)	(0.13)	(1.84)	(2.69)	(12.11)
Therapist, parent, current and past feeling	0.00	0.00	0.04	0.19	0.63	6.13
	(0.00)	(0.00)	(0.13)	(0.60)	(1.42)	(11.90)
Therapist, parent, past feeling and conflict	0.00	0.00	0.04	0.19	0.31	3.17
	(0.00)	(0.00)	(0.13)	(0.60)	(0.84)	(9.11)
Therapist, parent, current and past feeling and conflict	0.00	0.00	0.04	0.19	0.31	3.17
	(0.00)	(0.00)	(0.13)	(0.60)	(0.84)	(0.91)

The Six Therapy Groups

A series of one-way ANOVAs analysed differences between the six therapy groups of patients' explicit linking of transference components.

The first of these, for the percentage of statements in which references to parent and past feeling were linked, showed an overall significant effect of type of therapy ($F(5, 82) = 3.411$, $p<0.01$). Further analyses showed no significant differences between any two groups.

The linking of explicit references to the therapist and to current feelings showed an overall significant effect of type of therapy ($F(5, 82) = 23.963$, $p<0.001$). A priori contrasts showed that significantly more such links were made in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 6.420$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.319$, $p<0.001$) and Cognitive ($t(82) = 4.930$, $p<0.001$) therapy groups. A further series of a priori contrasts showed that the Psychoanalytic psychotherapy too contained significantly more such links than the Behaviour ($t(82) = 8.594$, $p<0.001$), Cognitive-behaviour ($t(82) = 7.544$, $p<0.001$), Cognitive ($t(82) = 7.198$, $p<0.001$), Conversational ($t(82) = 5.018$, $p<0.001$) and Psychodynamic ($t(82) = 3.643$, $p<0.001$) therapy groups.

The linking of explicit references to current feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 14.101$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group contained a significantly higher percentage of such links than the Behaviour ($t(82) = 3.954$, $p<0.001$) and Cognitive ($t(82) = 2.460$, $p<0.05$) therapy groups. A series of further a priori contrasts showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 7.539$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.418$, $p<0.001$), Cognitive ($t(82) = 6.050$, $p<0.001$), Conversational ($t(82) = 3.644$, $p<0.001$) and Psychodynamic ($t(82) = 5.009$, $p<0.001$) therapy groups.

An overall significant effect of type of therapy was shown for patients' linking of explicit references to parent and to conflict ($F(5, 82) = 4.584$, $p<0.001$). Further analyses showed no significant differences between any two groups.

An overall significant effect of type of therapy was shown for patients' linking of explicit references to current and to past feelings ($F(5, 82) = 5.056$, $p<0.001$). Further analyses showed significantly more such links were made in the Psychoanalytic psychotherapy group than in the Cognitive-behaviour therapy group (Scheffe test, $p<0.01$).

The linking of explicit references to therapist, current feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 8.067$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of statements containing such links than the Behaviour ($t(82) = 2.515$, $p<0.05$), Cognitive-behaviour ($t(82) = 2.171$, $p<0.05$) and Cognitive ($t(82) = 1.994$, $p<0.05$) therapy groups. A series of further a priori contrasts showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 5.245$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.816$, $p<0.001$), Cognitive ($t(82) = 4.658$, $p<0.001$), Conversational ($t(82) = 3.360$, $p<0.001$) and Psychodynamic ($t(82) = 3.740$, $p<0.001$) therapy groups.

The linking of explicit references to therapist and current and past feeling showed an overall significant effect of type of therapy ($F(5, 82) = 5.876$, $p<0.001$). Further analyses showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour therapy group (Scheffe test, $p<0.01$).

An overall significant effect of type of therapy was shown for patients' linking of explicit references to parent and current and to past feelings ($F(5, 82) = 3.373$, $p<0.01$). However further analyses did not indicate significant differences between any two of the six therapy groups.

An overall significant effect of type of therapy was shown for patients' linking of explicit references to therapist, parent and past feeling ($F(5, 82) = 3.380$, $p<0.01$). Further analyses showed significantly more such links were made in the Psychoanalytic psychotherapy group than in the Psychodynamic (Scheffe test, $p<0.05$).

An overall significant effect of type of therapy was shown for patients' linking of explicit references to therapist, parent and current feeling ($F(5, 82) = 7.973$, $p<0.001$). Further analyses showed significantly more such links were made in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.01$ and $p<0.001$ respectively).

The linking of explicit references to therapist, parent, and current and past feeling showed an overall significant effect of type of therapy ($F(5, 82) = 3.447$, $p<0.01$). Further analyses showed there to be no significant difference between any two groups.

No other analyses of patients' linking of explicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Explicit and Implicit Patient Statements - The percentage of patient statements within sessions in which various transference components were linked together by either explicit or implicit references to them was analysed. Thus, for example, an explicit reference to a current feeling linked to an implicit reference to the therapist would be counted as would linked explicit references to both components or linked implicit references to both. Mean percentages of each of such linked references are presented for the two therapy groupings Cognitive-behaviour (Behaviour, Cognitive-behaviour and Cognitive) and Psychodynamic (Conversational, Psychodynamic and Psychoanalytic) in Table 5.41 and for each of the six therapy groups in Table 5.42.

Table 5.41. Mean Percentage of explicit and implicit patient statements in which various transference referents are linked (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referents Linked				
Parent and past feeling	2.77	(2.84)	17.55	(16.22)
Therapist and current feeling	18.03	(10.51)	49.40	(19.83)
Current feeling and conflict	13.69	(7.26)	39.55	(18.51)
Parent and Conflict	2.17	(2.41)	16.66	(15.01)
Current and past feeling	4.41	(4.09)	20.09	(16.07)
Therapist, current feeling and conflict	8.61	(5.90)	30.43	(19.78)
Parent, past feeling and conflict	1.47	(1.91)	12.73	(14.86)
Therapist, current and past feeling	1.92	(2.59)	14.32	(14.73)
Parent, current and past feeling	2.46	(2.57)	16.99	(15.98)
Therapist, parent and past feeling	1.10	(1.58)	12.88	(14.79)
Therapist, parent and current feeling	1.21	(1.57)	16.89	(17.98)
Therapist, parent, current and past feeling	1.03	(1.54)	12.58	(14.65)
Therapist, parent, past feelings and conflict	0.58	(0.85)	9.03	(9.34)
Therapist, parent, current and past feeling and conflict	0.52	(0.76)	8.78	(9.15)

Table 5.42. Mean Percentage of explicit and implicit patient statements in which various transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh	Conversational		Psychoanalytic	
Referents Linked						
Parent and past feeling	1.03	4.35	3.27	10.35	14.27	29.13
	(2.03)	(2.74)	(2.85)	(7.94)	(11.25)	(22.74)
Therapist and current feeling	7.79	24.69	23.67	41.11	42.54	69.11
	(3.65)	(10.23)	(5.94)	(13.45)	(12.67)	(22.71)
Current feeling and conflict	9.17	16.59	16.22	29.52	35.17	55.27
	(2.73)	(9.30)	(6.52)	(9.01)	(10.13)	(26.36)
Parent and Conflict	0.77	3.42	2.61	8.62	11.67	32.31
	(1.41)	(2.91)	(2.13)	(6.88)	(8.41)	(18.41)
Current and past feeling	2.56	6.36	4.68	15.60	16.70	30.09
	(4.24)	(3.87)	(3.45)	(11.05)	(11.00)	(23.01)
Therapist, current feeling and conflict	5.07	11.49	9.97	22.47	24.36	48.27
	(3.08)	(8.26)	(3.48)	(7.57)	(10.98)	(27.83)
Parent, past feeling and conflict	0.24	2.51	1.93	6.98	8.92	24.45
	(0.52)	(2.17)	(2.00)	(6.92)	(6.90)	(21.33)
Therapist, current and past feeling	0.03	3.87	2.24	9.98	10.27	25.56
	(0.12)	(3.41)	(1.55)	(8.50)	(8.25)	(21.81)
Parent, current and past feeling	1.03	3.97	2.68	10.23	13.65	28.39
	(2.03)	(2.88)	(2.01)	(8.02)	(10.30)	(23.15)
Therapist, parent and past feeling	0.00	2.41	1.10	7.09	8.61	25.56
	(0.00)	(2.02)	(1.02)	(5.32)	(7.76)	(21.81)
Therapist, parent and current feeling	0.06	2.68	1.12	8.72	10.55	35.45
	(0.15)	(1.82)	(1.00)	(5.42)	(8.24)	(24.49)
Therapist, parent, current and past feeling	0.00	2.28	1.01	7.09	8.43	24.82
	(0.00)	(2.05)	(0.92)	(5.32)	(7.34)	(22.11)
Therapist, parent, past feeling and conflict	0.00	1.23	0.64	4.99	6.06	17.83
	(0.00)	(1.00)	(0.76)	(4.86)	(5.50)	(12.18)
Therapist, parent, current and past feeling and conflict	0.00	1.10	0.56	4.99	5.97	17.09
	(0.00)	(0.87)	(0.69)	(4.86)	(5.38)	(12.24)

The Two Therapy Groupings

Independent Samples t-Tests compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of patient statements in each in which the various transference components were linked together by either explicit or implicit references. These t-Tests showed the Psychodynamic therapies group to score significantly higher on all the links analysed: parent and past feeling ($t(86) = 5.101$, $p<0.001$), therapist and current feeling ($t(86) = 8.292$, $p<0.001$), current feeling and conflict ($t(86) = 7.560$, $p<0.001$), parent and conflict ($t(86) = 5.407$, $p<0.001$) current and past feeling ($t(86) = 5.408$, $p<0.001$), therapist, current feeling and conflict ($t(86) = 6.075$, $p<0.001$), parent, past feeling and conflict ($t(86) = 4.454$, $p<0001$), therapist, current and past feeling ($t(86) = 4.706$, $p<0.001$), parent, current and past feeling ($t(86) = 5.095$, $p<0.001$), therapist, parent and past feeling ($t(86) = 4.481$, $p<0.001$), therapist, parent and current feeling ($t(86) = 4.912$, $p<0.001$), therapist, parent, current and past feeling ($t(86) = 4.436$, $p<0.001$), therapist, parent, past feeling and conflict ($t(86) = 5.088$, $p<0.001$) and therapist, parent, current and past feeling, and conflict ($t(86) = 5.084$, $p<0.001$).

The Six Therapy Groups

A series of one-way ANOVAs analysed differences between the six therapy groups of patients linking of explicit and implicit references to transference components.

The first of these, for the percentage of statements in which references to parent and past feeling were linked, showed an overall significant effect of type of therapy ($F(5, 82) = 10.268$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.250$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.276$, $p<0.05$) and Cognitive ($t(82) = 2.524$, $p<0.05$) therapy groups. Further analyses showed a higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.05$ and $p<0.05$ respectively).

The linking of explicit and implicit references to therapist and current feeling showed an overall significant effect of type of therapy ($F(5, 82) = 32.69$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 11.681$, $p<0.001$), Cognitive-behaviour ($t(82) = 8.028$, $p<0.001$), Cognitive ($t(82) = 8.212$, $p<0.001$), Conversational ($t(82) = 5.060$, $p<0.001$) and Psychodynamic ($t(82) = 6.233$, $p<0.001$) therapy groups. A series of further a priori contrasts showed the Psychodynamic psychotherapy group contained a significantly higher

percentage of such links than the Behaviour (t (82) = 7.540, p<0.001), Cognitive-behaviour (t (82) = 3.621, p<0.001) and Cognitive (t (82) = 3.828, p<0.001) therapy groups. Further analyses showed the Conversational psychotherapy group contained a higher percentage of such references than the Behaviour therapy group (Scheffe test, p<0.001).

The linking of explicit and implicit references to current feeling and conflict showed an overall significant effect of type of therapy (F (5, 82) = 21.43, p<0.001). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour (t (82) = 6.728, p<0.001), Cognitive-behaviour (t (82) = 7.057, p<0.001), Cognitive (t (82) = 7.125, p<0.001), Conversational (t (82) = 4.698, p<0.001) and Psychodynamic (t (82) = 3.643, p<0.001) therapy groups. A series of further a priori contrasts showed the Psychodynamic psychotherapy group contained a significantly higher percentage of such links than the Behaviour (t (82) = 5.697, p<0.001), Cognitive-behaviour (t (82) = 3.806, p<0.001) and Cognitive (t (82) = 3.882, p<0.001) therapy groups.

An overall significant effect of type of therapy was shown for patients' linking of explicit and implicit references to parent and to conflict (F (5, 82) = 20.743, p<0.001). A priori contrasts showed significantly more such links were made in the Psychodynamic psychotherapy group than in the Behaviour (t (82) = 3.370, p<0.01), Cognitive-behaviour (t (82) = 2.384, p<0.05) and Cognitive (t (82) = 2.618, p<0.05) therapy groups. Further analyses also showed significantly more such links in the Psychoanalytic group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic (Scheffe tests, p<0.001, p<0.001, p<0.001, p<0.001 and p<0.001 respectively). These further analyses also showed the Psychodynamic psychotherapy group made more such links than did the Behaviour therapy group and this approached significance (Scheffe test, p<0.055).

An overall significant effect of type of therapy was shown for patients' linking of explicit and implicit references to current and past feeling (F (5, 82) = 9.31, p<0.001). A priori contrasts showed significantly more such links were made in the Psychodynamic psychotherapy group than in the Behaviour (t (82) = 3.357, p<0.01), Cognitive-behaviour (t (82) = 2.295, p<0.05) and Cognitive (t (82) = 2.668, p<0.01) therapy groups. Further analyses showed the Psychoanalytic psychotherapy group made more such links than the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic (Scheffe tests, p<0.001, p<0.001, p<0.001, p<0.001 and p<0.05 respectively) groups. These further analyses also showed that the Conversational psychotherapy group made more such links than did the Behaviour therapy group and this approached significance (Scheffe test, p<0.057).

The linking of explicit and implicit references to therapist, current feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 17.124$, $p<0.001$).). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 8.036$, $p<0.001$), Cognitive-behaviour ($t(82) = 6.490$, $p<0.001$), Cognitive ($t(82) = 6.578$, $p<0.001$), Conversational ($t(82) = 4.552$, $p<0.001$) and Psychodynamic ($t(82) = 5.475$, $p<0.001$) therapy groups. A series of further a priori contrasts showed the Psychodynamic psychotherapy group contained a significantly higher percentage of such links than the Behaviour ($t(82) = 4.089$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.550$, $p<0.05$) and Cognitive ($t(82) = 2.852$, $p<0.01$) therapy groups.

The linking of explicit and implicit references to parent, past feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 10.767$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour therapy group ($t(82) = 2.535$, $p<0.05$). Further analyses showed that the Psychoanalytic group contained more such links than the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.005$ and $p<0.05$ respectively).

An overall significant effect of type of therapy was shown for the linking of patients' explicit and implicit references to therapist and current and past feeling ($F(5, 82) = 10.038$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain more such links than the Behaviour ($t(82) = 2.803$, $p<0.01$) and the Cognitive ($t(82) = 2.056$, $p<0.05$) therapy groups. The Psychoanalytic psychotherapy group was shown by further analyses to contain a significantly higher percentage of statements with such links than the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.01$, $p<0.001$, $p<0.05$ and $p<0.005$ respectively).

An overall significant effect of type of therapy was shown for the linking of patients' explicit and implicit references to parent and current and past feeling ($F(5, 82) = 10.188$, $p<0.001$). A priori contrasts showed the Psychodynamic group to contain a significantly higher percentage of statements containing such links than the Behaviour ($t(82) = 3.145$, $p<0.005$), Cognitive-behaviour ($t(82) = 2.254$, $p<0.05$) and Cognitive ($t(82) = 2.554$, $p<0.05$) therapy groups. Further analyses showed the Psychoanalytic psychotherapy group to contain a significantly higher percentage of statements containing such links than were shown in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.05$ and $p<0.05$ respectively).

The linking of explicit and implicit references to therapist, parent and past feeling showed an overall significant effect of type of therapy ($F(5, 82) = 11.545$, $p<0.001$). A priori contrasts showed the Psychodynamic group to contain a significantly higher percentage of statements containing such links than the Behaviour ($t(82) = 2.450$, $p<0.05$) and Cognitive ($t(82) = 1.998$, $p<0.05$) therapy groups. Further analyses showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.005$ and $p<0.001$ respectively).

The linking of explicit and implicit references to therapist, parent and current feeling showed an overall significant effect of type of therapy ($F(5, 82) = 18.520$, $p<0.001$). A priori contrasts showed the Psychodynamic group to contain a significantly higher percentage of statements containing such links than the Behaviour ($t(82) = 2.697$, $p<0.01$) and Cognitive ($t(82) = 2.266$, $p<0.05$) therapy groups. Further analyses showed a significantly higher percentage of statements containing such links in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.001$ respectively).

Analysis, between groups, of patients' linking of explicit and implicit references to therapist, parent and current and past feeling, showed an significant overall effect of therapy type ($F(5, 82) = 10.909$, $p<0.001$). A priori contrasts showed a higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour therapy group ($t(82) = 2.397$, $p<0.05$). With further analyses a significantly higher percentage of statements containing such links was also identified in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.01$ and $p<0.001$ respectively).

An overall significant effect of type of therapy was shown for the linking of patients' explicit and implicit references to therapist, parent, past feeling and conflict ($F(5, 82) = 15.602$, $p<0.001$). A priori contrasts showed the Psychodynamic group to contain a significantly higher percentage of statements containing such links than the Behaviour ($t(82) = 2.849$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.123$, $p<0.05$) and Cognitive ($t(82) = 2.383$, $p<0.05$) therapy groups. Again, further analyses showed the Psychoanalytic psychotherapy group to contain a significantly higher percentage of statements containing such links than were shown in the Behaviour, Cognitive-

behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.001$ respectively).

Finally, an overall significant effect of type of therapy was also shown for the linking of patients' explicit and implicit references to therapist, parent, current and past feeling and conflict ($F(5, 82) = 14.510$, $p<0.001$). Again a priori contrasts showed the Psychodynamic group to contain a significantly higher percentage of statements containing such links than the Behaviour ($t(82) = 2.817$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.148$, $p<0.05$) and Cognitive ($t(82) = 2.387$, $p<0.05$) therapy groups. Yet again, further analyses showed the Psychoanalytic psychotherapy group to contain a significantly higher percentage of statements containing such links than were shown in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.001$ respectively).

No other analyses of patients' linking of explicit and implicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Linking of transference components in patient statements

Support was obtained for the hypothesis that the various combinations of linking of the individual transference components would each occur in a higher percentage of patient statements in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping. All types of links of patient combined explicit and implicit references and the majority of types of links of patient explicit references occurred more often in the Psychodynamic grouping of therapies than in the Cognitive-behaviour. No links occurred more often in the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that the Psychoanalytic psychotherapy group would contain a higher percentage of patient statements than all other groups linking therapist and current feeling; current feeling and conflict; and therapist, current feeling and conflict.

Support was obtained for the hypothesis that the Psychodynamic psychotherapy group would contain a higher percentage of patient statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups containing references linking the therapist and current feeling; current

feeling and conflict; and therapist, current feeling and conflict.

The Psychoanalytic psychotherapy group had a higher occurrence than the other five therapy groups of the majority of the analysed combinations of linking of explicit references and explicit and implicit references combined. The exceptions to this tended to be of linking of explicit references which included reference to past feelings.

None of the links of explicit references that it were hypothesised would occur in a higher percentage of patient statements in the Psychodynamic psychotherapy group than in all other groups did so. However, partial support was obtained for the links of explicit and implicit references combined that it was hypothesised would occur in a higher percentage of patient statements in the Psychodynamic group. The majority of these hypothesised links occurred more in the Psychodynamic group than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

ii) Therapist Statements

This section of analyses includes testing of the hypotheses that:

i) the Psychodynamic grouping of therapies will contain a higher number of therapist statements than the Cognitive-behaviour grouping of therapies linking the therapist and current feeling; therapist and parent; therapist and conflict; parent and past feeling; parent and conflict; current feeling and conflict; current feeling and past feeling; therapist, current and past feeling; therapist, current feeling and conflict; parent, current feeling and past feeling; parent, past feeling and conflict; therapist, parent and current feeling; therapist, parent and past feeling; therapist, parent and current feeling; therapist, parent, current feeling and past feeling; and therapist, parent, current feeling, past feeling and conflict.

ii) the Psychodynamic psychotherapy group will contain a higher number of therapist statements than other groups including the Psychoanalytic and Conversational psychotherapy groups linking therapist and parent; parent and past feeling; parent and conflict; current and past feeling; therapist, current feeling and past feeling; therapist, parent and current feeling; parent and past feeling and current feeling; parent, past feeling and conflict; therapist, parent and current feeling; therapist, parent and past feeling; therapist, parent, current feeling and past feeling; therapist, parent, past feeling and conflict; and therapist, parent, current feeling, past feeling and conflict.

iii) the Psychodynamic psychotherapy group will contain a higher number of therapist statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups linking therapist and current feeling; current feeling and conflict; and therapist, current feeling and conflict

iv) the Psychoanalytic psychotherapy group will contain a higher number of therapist statements than other groups including the Psychodynamic and the Conversational psychotherapy groups linking current feeling and therapist; current feeling and conflict; current feeling, therapist and conflict.

Explicit Therapist Statements - The percentage of therapist statements within sessions in which explicit references to transference components were linked together was analysed. Mean percentages of each of these linked references are presented for the two therapy groupings Cognitive-behaviour (Behaviour, Cognitive-behaviour and Cognitive) and Psychodynamic (Conversational, Psychodynamic and Psychoanalytic) in Table 5.43 and for each of the six therapy groups in Table 5.44.

Table 5.43. Mean Percentage of therapist statements in which explicit transference referents are linked (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referents Linked				
Parent and past feeling	0.15	(0.61)	2.13	(4.35)
Therapist and current feeling	1.74	(2.39)	21.00	(13.04)
Current feeling and conflict	2.18	(3.28)	9.97	(8.52)
Parent and Conflict	0.25	(0.82)	1.86	(3.05)
Current and past feeling	0.18	(0.63)	2.37	(5.19)
Therapist, current feeling and conflict	0.18	(0.52)	5.56	(7.17)
Parent, past feeling and conflict	0.00	(0.00)	0.75	(1.69)
Therapist, current and past feeling	0.02	(0.09)	0.59	(1.62)
Parent, current and past feeling	0.06	(0.29)	1.06	(2.29)
Therapist, parent and past feeling	0.00	(0.00)	0.31	(0.93)
Therapist, parent and current feeling	0.00	(0.00)	2.09	(5.06)
Therapist, parent, current and past feeling	0.00	(0.00)	0.31	(0.93)
Therapist, parent, past feelings and conflict	0.00	(0.00)	0.25	(0.88)
Therapist, parent, current and past feeling and conflict	0.00	(0.00)	0.25	(0.88)

Table 5.44. Mean Percentage of therapist statements in which explicit transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Parent and past feeling	0.00	0.00	0.48	1.32	2.88	1.11
	(0.00)	(0.00)	(1.05)	(2.36)	(4.80)	(4.31)
Therapist and current feeling	0.38	1.87	3.23	13.77	21.21	25.41
	(0.40)	(1.14)	(3.64)	(10.02)	(10.14)	(18.03)
Current feeling and conflict	0.10	3.67	3.17	7.67	9.59	12.29
	(0.20)	(4.68)	(2.39)	(6.14)	(6.45)	(12.72)
Parent and Conflict	0.00	0.08	0.71	1.27	2.94	0.00
	(0.00)	(0.25)	(1.38)	(1.70)	(3.63)	(0.00)
Current and past feeling	0.04	0.00	0.53	2.10	1.84	3.63
	(0.14)	(0.00)	(1.06)	(2.20)	(3.01)	(9.00)
Therapist, current feeling and conflict	0.00	0.18	0.41	1.73	5.47	8.31
	(0.00)	(0.41)	(0.82)	(2.03)	(5.17)	(11.11)
Parent, past feeling and conflict	0.00	0.00	0.00	0.48	1.20	0.00
	(0.00)	(0.00)	(0.00)	(0.79)	(2.12)	(0.00)
Therapist, current and past feeling	0.00	0.00	0.05	0.44	0.60	0.67
	(0.00)	(0.00)	(0.16)	(0.72)	(1.24)	(2.58)
Parent, current and past feeling	0.00	0.00	0.20	0.95	1.61	0.00
	(0.00)	(0.00)	(0.51)	(1.39)	(2.86)	(0.00)
Therapist, parent and past feeling	0.00	0.00	0.00	0.32	0.45	0.00
	(0.00)	(0.00)	(0.00)	(0.68)	(1.16)	(0.00)
Therapist, parent and current feeling	0.00	0.00	0.00	0.32	2.60	2.22
	(0.00)	(0.00)	(0.00)	(0.68)	(3.32)	(8.60)
Therapist, parent, current and past feeling	0.00	0.00	0.00	0.32	0.45	0.00
	(0.00)	(0.00)	(0.00)	(0.68)	(1.16)	(0.00)
Therapist, parent, past feeling and conflict	0.00	0.00	0.00	0.17	0.39	0.00
	(0.00)	(0.00)	(0.00)	(0.54)	(1.13)	(0.00)
Therapist, parent, current and past feeling and conflict	0.00	0.00	0.00	0.17	0.39	0.00
	(0.00)	(0.00)	(0.00)	(0.54)	(1.13)	(0.00)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare therapists from the Psychodynamic grouping of psychotherapies and the Cognitive-behaviour grouping of therapies in their linking of explicit references to transference components. These tests showed the Psychodynamic psychotherapies grouping to contain a significantly higher percentage of therapist statements in which links were made between: parent and past feeling ($t(86) = 2.549$, $p<0.05$), therapist and current feeling ($t(86) = 8.260$, $p<0.001$), current feeling and conflict ($t(86) = 4.961$, $p<0.001$), parent and conflict ($t(86) = 2.915$, $p<0.005$) current and past feeling ($t(86) = 2.364$, $p<0.05$), therapist, current feeling and conflict ($t(86) = 4.225$, $p<0.001$), parent, past feeling and conflict ($t(86) = 2.505$, $p<0.05$), therapist, current and past feeling ($t(86) = 1.992$, $p<0.05$), parent, current and past feeling ($t(86) = 2.444$, $p<0.05$), and therapist, parent and current feeling ($t(86) = 2.333$, $p<0.05$). The linking of references to therapist, parent, current and past feeling and to therapist, parent and past feeling both showed a higher occurrence in the psychodynamic psychotherapy group and this approached significance ($t(86) = 1.889$, $p<0.062$ and $t(86) = 1.889$, $p<0.062$ respectively).

The Six Therapy Groups

A series of one-way ANOVAs analysed differences between the six therapy groups of therapists' linking of explicit references to transference components.

The linking of explicit references to therapist and current feeling showed an overall significant effect of type of therapy ($F(5, 82) = 15.927$, $p<0.001$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 5.957$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.171$, $p<0.001$) and Cognitive ($t(82) = 4.808$, $p<0.01$) therapy groups. A further series of a priori contrasts showed significantly more such links were made by therapists in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 6.284$, $p<0.001$), Cognitive-behaviour ($t(82) = 5.607$, $p<0.001$), Cognitive ($t(82) = 5.283$, $p<0.01$) and Conversational ($t(82) = 2.772$, $p<0.01$) therapy groups.

The linking of explicit references to current feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 5.836$, $p<0.001$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.947$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.302$, $p<0.05$) and Cognitive ($t(82) = 2.497$, $p<0.05$) therapy groups. A further series of a priori contrasts showed significantly more such links were made by therapists in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 4.450$, $p<0.001$), Cognitive-behaviour ($t(82) = 2.986$, $p<0.005$) and Cognitive ($t(82) = 3.159$, $p<0.005$) therapy groups.

An overall significant effect of type of therapy was shown for therapists' linking of explicit references to parent and to conflict ($F(5, 82) = 5.517$, $p<0.001$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.742$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.403$, $p<0.001$), Cognitive ($t(82) = 2.654$, $p<0.01$), Conversational ($t(82) = 1.981$, $p<0.05$) and Psychoanalytic ($t(82) = 4.516$, $p<0.001$) therapy groups.

An overall significant effect of type of therapy was shown for therapists' linking of explicit references to therapist, current feeling and conflict ($F(5, 82) = 5.414$, $p<0.001$).
A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 2.869$, $p<0.005$), Cognitive-behaviour ($t(82) = 2.594$, $p<0.05$) and Cognitive ($t(82) = 2.481$, $p<0.05$) therapy groups. A further series of a priori contrasts showed significantly more such links were made by therapists in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 3.829$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.554$, $p<0.001$), Cognitive ($t(82) = 3.454$, $p<0.001$) and Conversational ($t(82) = 2.877$, $p<0.005$) therapy groups.

The linking of explicit references to parent, past feeling and conflict in therapist statements showed an overall significant effect of type of therapy ($F(5, 82) = 3.113$, $p<0.05$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 2.685$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.510$, $p<0.05$), Cognitive ($t(82) = 2.510$, $p<0.05$) and Psychoanalytic ($t(82) = 2.902$, $p<0.005$) therapy groups.

Therapists' linking of explicit references to parent, current and past feeling showed an overall significant effect of type of therapy ($F(5, 82) = 2.897$, $p<0.05$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 2.631$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.459$, $p<0.05$), Cognitive ($t(82) = 2.153$, $p<0.05$) and Psychoanalytic ($t(82) = 2.844$, $p<0.01$) therapy groups.

No other analyses of therapists' linking of explicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Explicit and Implicit Therapist Statements - The percentage of therapist statements within sessions in which various transference components were linked together by either explicit or implicit references to them was analysed. Mean percentages of each of these linked references are

presented for the two therapy groupings Cognitive-behaviour (Behaviour, Cognitive-behaviour and Cognitive) and Psychodynamic (Conversational, Psychodynamic and Psychoanalytic) in Table 5.45 and for each of the six therapy groups in Table 5.46.

Table 5.45. Mean Percentage of therapist statements in which explicit and implicit transference referents are linked (standard deviation in brackets)

Group Referents Linked	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Parent and past feeling	0.65	(1.49)	5.36	(6.36)
Therapist and current feeling	6.23	(6.63)	28.63	(14.96)
Current feeling and conflict	4.21	(5.52)	21.47	(13.66)
Parent and Conflict	0.50	(1.14)	4.63	(5.57)
Current and past feeling	1.09	(1.80)	5.07	(5.23)
Therapist, current feeling and conflict	1.71	(2.72)	13.60	(11.54)
Parent, past feeling and conflict	0.11	(0.31)	2.61	(3.66)
Therapist, current and past feeling	0.47	(0.99)	2.39	(3.30)
Parent, current and past feeling	0.50	(1.31)	3.55	(3.98)
Therapist, parent and past feeling	0.28	(0.76)	1.79	(2.85)
Therapist, parent and current feeling	0.39	(0.82)	3.74	(6.01)
Therapist, parent, current and past feeling	0.25	(0.75)	1.62	(2.46)
Therapist, parent, past feelings and conflict	0.04	(0.15)	1.22	(2.08)
Therapist, parent, current and past feeling and conflict	0.04	(0.15)	1.22	(2.08)

The Two Therapy Groupings

Independent Samples t-Tests compared the grouped Psychodynamic psychotherapies (Conversational, Psychodynamic and Psychoanalytic) and the grouped Cognitive-behaviour therapies (Behaviour, Cognitive-behaviour and Cognitive) with respect to the percentage of therapist statements in each in which the various transference components were linked together by either explicit or implicit references. These t-Tests showed the Psychodynamic therapies group to score significantly higher on all the links analysed: parent and past feeling ($t(86) = 4.121$, $p<0.001$), therapist and current feeling ($t(86) = 8.016$, $p<0.001$), current feeling and conflict ($t(86) = 6.821$, $p<0.001$), parent and conflict ($t(86) = 4.132$, $p<0.001$) current and past feeling ($t(86) = 4.162$, $p<0.001$), therapist, current feeling and conflict ($t(86) = 5.725$, $p<0.001$), parent, past feeling and conflict ($t(86) = 3.861$, $p<0001$), therapist, current and past feeling ($t(86) = 3.219$, $p<0.005$), parent, current and past feeling ($t(86) = 4.209$, $p<0.001$), therapist, parent and past feeling ($t(86) = 2.940$, $p<0.005$), therapist, parent and current feeling ($t(86) = 3.129$,

Table 5.46. Mean Percentage of therapist statements in which explicit and implicit transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.	Conversational		Psychoanalytic	
Referents Linked						
Parent and past feeling	0.00	0.55	1.53	5.27	7.45	1.11
	(0.00)	(1.74)	(1.78)	(4.26)	(6.81)	(4.31)
Therapist and current feeling	0.48	8.67	10.70	26.03	27.97	32.10
	(0.52)	(7.04)	(5.34)	(12.32)	(13.78)	(18.85)
Current feeling and conflict	0.54	6.46	6.36	17.06	19.97	27.49
	(0.20)	(4.68)	(2.39)	(6.14)	(6.45)	(12.72)
Parent and Conflict	0.00	0.54	1.05	2.12	6.56	2.29
	(0.00)	(1.19)	(1.55)	(2.30)	(5.39)	(6.13)
Current and past feeling	0.09	1.11	2.26	5.82	6.24	2.15
	(0.22)	(1.71)	(2.30)	(4.32)	(4.60)	(6.12)
Therapist, current feeling and conflict	0.11	2.28	3.06	9.64	12.71	18.06
	(0.22)	(3.62)	(2.55)	(7.21)	(9.55)	(16.12)
Parent, past feeling and conflict	0.00	0.00	0.34	1.64	4.19	0.00
	(0.00)	(0.00)	(0.49)	(1.81)	(4.15)	(0.00)
Therapist, current and past feeling	0.00	0.31	1.18	1.82	3.05	1.41
	(0.00)	(0.98)	(1.23)	(2.14)	(3.32)	(3.72)
Parent, current and past feeling	0.00	0.55	1.04	4.25	5.05	0.00
	(0.00)	(1.74)	(1.48)	(3.64)	(4.03)	(0.00)
Therapist, parent and past feeling	0.00	0.31	0.59	1.41	2.79	0.00
	(0.00)	(0.98)	(0.91)	(1.85)	(3.34)	(0.00)
Therapist, parent and current feeling	0.00	0.72	0.52	1.92	4.41	3.55
	(0.00)	(1.09)	(0.89)	(2.88)	(4.26)	(9.71)
Therapist, parent, current and past feeling	0.00	0.31	0.48	1.41	2.47	0.00
	(0.00)	(0.98)	(0.91)	(1.85)	(2.83)	(0.00)
Therapist, parent, past feeling and conflict	0.00	0.00	0.12	0.34	2.10	0.00
	(0.00)	(0.00)	(0.26)	(1.08)	(2.41)	(0.00)
Therapist, parent, current and past feeling and conflict	0.00	0.00	0.12	0.34	2.10	0.00
	(0.00)	(0.00)	(0.26)	(1.08)	(2.41)	(0.00)

$p<0.005$), therapist, parent, current and past feeling ($t(86) = 3.070$, $p<0.005$), therapist, parent, past feeling and conflict ($t(86) = 3.204$, $p<0.005$) and therapist, parent, current and past feeling, and conflict ($t(86) = 3.204$, $p<0.005$).

The Six Therapy Groups

A series of one-way ANOVAs analysed differences between the six therapy groups of therapists linking of explicit and implicit references to transference components.

The first of these, for the percentage of statements in which references to parent and past feeling were linked, showed an overall significant effect of type of therapy ($F(5, 82) = 5.537$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.587$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.971$, $p<0.001$), Cognitive ($t(82) = 3.408$, $p<0.001$) and Psychoanalytic ($t(82) = 4.217$, $p<0.001$) therapy groups.

The linking of explicit and implicit references to therapist and current feeling showed an overall significant effect of type of therapy ($F(5, 82) = 4.670$, $p<0.001$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 6.444$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.216$, $p<0.001$) and Cognitive ($t(82) = 3.769$, $p<0.001$) therapy groups. A further series of a priori contrasts showed significantly more such links were made by therapists in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 6.550$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.603$, $p<0.001$) and Cognitive ($t(82) = 4.205$, $p<0.001$) therapy groups. Further analyses showed the Conversational psychotherapy group contained a significantly higher percentage of statements than the Behaviour therapy group linking references to the therapist and current feeling (Scheffe test, $p<0.001$).

The linking of explicit and implicit references to current feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 12.963$, $p<0.001$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 5.138$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.340$, $p<0.001$) and Cognitive ($t(82) = 3.365$, $p<0.001$) therapy groups. A further series of a priori contrasts showed significantly more such links were made by therapists in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 6.257$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.632$, $p<0.001$), Cognitive ($t(82) = 4.654$, $p<0.001$) and Conversational ($t(82) = 2.298$, $p<0.05$) therapy groups.

An overall significant effect of type of therapy was shown for patients' linking of explicit and implicit references to parent and to conflict ($F(5, 82) = 7.501$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.544$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.899$, $p<0.001$), Cognitive ($t(82) = 3.569$, $p<0.001$), Conversational ($t(82) = 2.876$, $p<0.005$) and Psychoanalytic ($t(82) = 3.201$, $p<0.005$) therapy groups.

An overall significant effect of type of therapy was shown for patients' linking of explicit and implicit references to current and past feeling ($F(5, 82) = 5.325$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.376$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.413$, $p<0.001$), Cognitive ($t(82) = 2.648$, $p<0.01$) and Psychoanalytic ($t(82) = 3.149$, $p<0.005$) therapy groups.

The linking of therapists' explicit and implicit references to therapist, current feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 12.181$, $p<0.001$). A priori contrasts showed significantly more such links were made by therapists in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.007$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.101$, $p<0.005$) and Cognitive ($t(82) = 2.869$, $p<0.005$) therapy groups. A further series of a priori contrasts showed significantly more such links were made by therapists in the Psychoanalytic psychotherapy group than in the Behaviour ($t(82) = 5.010$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.178$, $p<0.001$), Cognitive ($t(82) = 3.972$, $p<0.001$) and Conversational ($t(82) = 2.229$, $p<0.05$) therapy groups.

The linking of explicit and implicit references to parent, past feeling and conflict showed an overall significant effect of type of therapy ($F(5, 82) = 20.163$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.767$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.457$, $p<0.001$), Cognitive ($t(82) = 4.059$, $p<0.001$), Conversational ($t(82) = 2.712$, $p<0.01$) and Psychoanalytic ($t(82) = 5.153$, $p<0.001$) therapy groups.

An overall significant effect of type of therapy was shown for statements linking explicit and implicit references to therapist, current and past feeling ($F(5, 82) = 7.218$, $p<0.001$).

A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.354$, $p<0.001$) and Cognitive-behaviour ($t(82) = 2.818$, $p<0.01$) therapy groups.

An overall significant effect of type of therapy was shown for statements linking explicit and implicit references to parent, current and past feeling ($F(5, 82) = 14.854$, $p<0.001$).
A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 5.258$, $p<0.001$), Cognitive-behaviour ($t(82) = 4.379$, $p<0.001$), Cognitive ($t(82) = 3.902$, $p<0.001$) and Psychoanalytic ($t(82) = 5.683$, $p<0.001$) therapy groups.

The linking of explicit and implicit references to therapist, parent and past feeling showed an overall significant effect of type of therapy ($F(5, 82) = 11.447$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.799$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.157$, $p<0.005$), Cognitive ($t(82) = 2.800$, $p<0.01$) and Psychoanalytic ($t(82) = 4.107$, $p<0.001$) therapy groups.

The linking of explicit and implicit references to therapist, parent and current feeling showed an overall significant effect of type of therapy ($F(5, 82) = 6.244$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 2.657$, $p<0.01$), Cognitive-behaviour ($t(82) = 2.078$, $p<0.05$) and Cognitive ($t(82) = 2.191$, $p<0.05$) therapy groups.

The analysis of therapists linking within statements of explicit and implicit references to therapist, parent, current and past feeling showed an overall effect of type of therapy that was significant ($F(5, 82) = 13.256$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 3.888$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.179$, $p<0.005$), Cognitive ($t(82) = 2.929$, $p<0.005$) and Psychoanalytic ($t(82) = 4.203$, $p<0.001$) therapy groups.

An overall significant effect of type of therapy was shown for therapists' statements linking explicit and implicit references to therapist, parent, past feeling and conflict ($F(5, 82) = 12.964$, $p<0.001$). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour ($t(82) = 4.104$, $p<0.001$), Cognitive-behaviour ($t(82) = 3.837$, $p<0.001$), Cognitive ($t(82) = 3.617$, $p<0.001$),

Conversational (t (82) = 3.215, p<0.005) and Psychoanalytic (t (82) = 4.437, p<0.001) therapy groups.

Finally, an overall significant effect of type of therapy was shown for therapists' statements linking explicit and implicit references to therapist, parent, current and past feeling and conflict (F (5, 82) = 12.964, p<0.001). A priori contrasts showed a significantly higher percentage of statements containing such links in the Psychodynamic psychotherapy group than in the Behaviour (t (82) = 4.104, p<0.001), Cognitive-behaviour (t (82) = 3.837, p<0.001), Cognitive (t (82) = 3.617, p<0.001), Conversational (t (82) = 3.215, p<0.005) and Psychoanalytic (t (82) = 4.437, p<0.001) therapy groups.

No other analyses of therapists' linking of explicit and implicit references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Linking of transference components in therapist statements

Support was obtained for the hypothesis that the various combinations of linking of the individual transference components would each occur in a higher percentage of therapist statements in the Psychodynamic grouping of therapies than in the Cognitive-behaviour grouping. All types of links of therapist combined explicit and implicit references and the majority of types of links of therapist explicit references occurred more often in the Psychodynamic grouping of therapies than in the Cognitive-behaviour. No links occurred more often in the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that the Psychodynamic psychotherapy group would contain a higher percentage of therapist statements than the Behaviour, Cognitive-behaviour and Cognitive therapy groups linking therapist and current feeling; current feeling and conflict; and therapist, current feeling and conflict.

Partial support was obtained for the hypothesis that the Psychoanalytic psychotherapy group would contain a higher percentage of therapist statements than other groups linking therapist and current feeling; current feeling and conflict; and therapist, current feeling and conflict. The group had a higher percentage of statements containing these links than other groups with the exception of the Psychodynamic group.

Partial support was obtained for the links hypothesised to occur in a higher percentage of therapist statements in the Psychodynamic psychotherapy group than in all other groups. The group contained a higher percentage of statements containing a few of the analysed links of explicit references and the majority of the links of combined explicit and implicit references than did the Behaviour, Cognitive-behaviour, Cognitive and Psychoanalytic groups. Thus for example it contained more linking of explicit and implicit references combined to parent and past feeling; parent and conflict; current feeling and past feeling; parent, past feeling and current feeling; parent, past feeling and conflict; therapist, parent and past feeling; therapist, parent, current feeling and past feeling; therapist, parent, past feeling and conflict; and therapist, parent' past feeling, current feeling and conflict than the Behaviour, Cognitive-behaviour, Cognitive and Psychoanalytic groups. Of these links the Psychodynamic group also contained more links of parent and conflict; parent, past feeling and conflict; therapist, parent, past feeling and conflict; and therapist, parent, current feeling, past feeling and conflict than did the Conversational group.

5.4 Comparison of Transference References across Early and Late Sessions and by Type of Therapy

Patients' and therapists' explicit and implicit references to transference components were analysed across early and late sessions of therapy and by type of therapy. These analyses explored:

i) the percentage of statements in sessions containing references to individual transference components across early and late sessions and therapy type

ii) the percentage of statements in sessions in which various transference components were linked together across early and late sessions and therapy type

iii) the number of references to individual transference components in each patient and in each therapist statement

iv) the number of references to individual transference components per patient and per therapist line of narrative (rate)

v) the number of different types of transference component referred to per patient and per therapist line of narrative (rate)

vi) the number of different types of transference component referred to per patient and per therapist statement

5.4.1 Individual Transference Components

i) Patient Explicit Reference to Individual Transference Components

The percentage of statements by patients in which each of the five potential references to transference components were explicitly made was analysed. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.47. The results of this analysis across the six therapy groups is presented in Table 5.48.

The number of explicit references in each patient statement to the five transference component was analysed. The results of this analysis across the Cognitive-behaviour and Psychodynamic therapies is presented in Table 5.49. The results of the analysis across the six therapies is presented in Table 5.50.

The rate of patient references to each of the transference components was analysed. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.51. These rates analysed across the six therapy groups are presented in Table 5.52.

The number of different transference components explicitly referred to in each patient statement and per line of patient statement were also analysed. The results of these analyses across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.53. The results analysed across the six therapy groups are presented in Table 5.54.

This section of analyses includes testing of the hypotheses that:

i) patients' explicit references to transference components will be higher in late than in early sessions of both the Psychodynamic and the Cognitive-behaviour grouping of therapies

ii) patients' explicit references to transference components will be higher in late than in early sessions of all six therapy groups

iii) patients' explicit references to transference components will be higher in the Psychoanalytic and Psychodynamic psychotherapy groups than in the other four therapy groups and will increase more in late over early sessions

Table 5.47. Percentage of patient statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which each transference component was explicitly identified (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	4.52	4.02	28.52	24.95
	(3.85)	(3.43)	(22.85)	(13.24)
Parent	2.58	2.20	14.75	21.16
	(3.48)	(3.10)	(12.33)	(22.61)
Current feeling	61.16	70.13	79.87	81.32
	(14.16)	(11.19)	(10.91)	(8.82)
Past feeling	1.75	1.40	8.40	8.63
	(2.67)	(2.72)	(11.18)	(12.89)
Conflict	7.89	5.71	19.38	25.23
	(8.73)	(4.86)	(9.59)	(12.83)

Table 5.48. Percentage of patient statements across early and late sessions and by type of therapy in which each of the 10 transference components were explicitly identified (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Referent					
Therapist (E)	1.23	4.24	7.35	16.36	24.63	66.70
	(1.37)	(2.81)	(4.57)	(14.88)	(14.38)	(9.76)
Therapist (L)	0.87	5.22	4.88	17.40	33.45	26.80
	(1.50)	(1.91)	(4.82)	(10.05)	(15.94)	(7.54)
Parent (E)	3.60	2.44	2.83	6.40	18.67	27.75
	(6.06)	(2.45)	(3.32)	(5.49)	(14.03)	(7.85)
Parent (L)	0.93	2.82	2.38	7.06	19.90	58.95
	(1.62)	(4.19)	(2.79)	(6.03)	(14.08)	(22.70)
Current feeling (E)	65.50	56.92	63.20	79.76	78.28	83.35
	(13.39)	(15.96)	(14.88)	(9.15)	(9.04)	(23.55)
Current feeling (L)	72.23	72.08	62.10	78.98	81.15	87.50
	(18.79)	(10.93)	(6.65)	(5.23)	(9.17)	(17.68)
Past feeling (E)	2.23	1.00	2.33	3.64	10.23	16.65
	(3.70)	(1.65)	(3.43)	(2.94)	(11.53)	(23.55)
Past feeling (L)	0.17	1.02	2.80	3.52	8.60	21.45
	(0.90)	(1.07)	(4.71)	(3.29)	(8.90)	(30.34)
Conflict (E)	4.50	11.08	6.45	13.90	19.28	33.30
	(3.90)	(12.87)	(4.20)	(4.85)	(9.79)	(13.34)
Conflict (L)	0.90	9.30	4.83	20.10	24.60	39.30
	(0.78)	(5.31)	(1.75)	(7.98)	(14.52)	(15.13)

Table 5.49. The mean number of explicit references in a patient statement to each transference component across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.047	0.041	0.417	4.413
	(0.038)	(0.034)	(0.388)	(9.250)
Parent	0.053	0.034	0.334	0.534
	(0.083)	(0.055)	(0.370)	(1.012)
Current feeling	0.987	1.100	2.547	3.458
	(0.536)	(0.375)	(1.835)	(1.310)
Past feeling	0.030	0.016	0.186	0.107
	(0.051)	(0.034)	(0.359)	(0.172)
Conflict	0.091	0.062	0.265	0.344
	(0.107)	(0.056)	(0.209)	(0.214)

Table 5.50. The mean number of explicit references in a patient statement to each transference component across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Referent						
Therapist (E)	0.012	0.047	0.073	0.234	0.327	1.055
	(0.014)	(0.026)	(0.045)	(0.225)	(0.213)	(0.389)
Therapist (L)	0.009	0.054	0.049	3.191	0.363	15.250
	(0.015)	(0.019)	(0.048)	(6.603)	(0.150)	(19.445)
Parent (E)	0.094	0.046	0.033	0.108	0.422	0.720
	(0.161)	(0.057)	(0.038)	(0.149)	(0.361)	(0.552)
Parent (L)	0.010	0.052	0.029	0.081	0.219	1.965
	(0.017)	(0.079)	(0.037)	(0.067)	(0.090)	(2.171)
Current feeling (E)	1.010	1.162	0.750	1.714	2.808	4.110
	(0.693)	(0.649)	(0.210)	(1.258)	(0.819)	(4.087)
Current feeling (L)	0.987	1.420	0.785	2.590	0.853	4.445
	(0.389)	(0.254)	(0.114)	(0.967)	(0.275)	(1.846)
Past feeling (E)	0.057	0.017	0.023	0.047	0.147	0.610
	(0.098)	(0.024)	(0.034)	(0.044)	(0.158)	(0.863)
Past feeling (L)	0.002	0.010	0.034	0.035	0.086	0.285
	(0.003)	(0.011)	(0.058)	(0.033)	(0.059)	(0.403)
Conflict (E)	0.055	0.134	0.064	0.156	0.258	0.555
	(0.058)	(0.156)	(0.041)	(0.054)	(0.177)	(0.318)
Conflict (L)	0.009	0.104	0.050	0.242	0.157	0.520
	(0.008)	(0.061)	(0.020)	(0.100)	(0.094)	(0.325)

Table 5.51. The rate of explicit references to individual transference components across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.018	0.015	0.062	0.761
	(0.014)	(0.012)	(0.045)	(1.597)
Parent	0.013	0.013	0.053	0.043
	(0.018)	(0.019)	(0.064)	(0.052)
Current feeling	0.037	0.434	0.396	0.441
	(0.112)	(0.109)	(0.177)	(0.136)
Past feeling	0.007	0.006	0.034	0.011
	(0.012)	(0.013)	(0.062)	(0.018)
Conflict	0.027	0.022	0.044	0.041
	(0.020)	(0.016)	(0.035)	(0.017)

Table 5.52. The rate of explicit references to individual transference components across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Referent						
Therapist (E)	0.008	0.015	0.031	0.042	0.058	0.123
	(0.011)	(0.008)	(0.014)	(0.036)	(0.041)	(0.017)
Therapist (L)	0.005	0.017	0.020	0.954	0.075	1.651
	(0.009)	(0.006)	(0.018)	(2.055)	(0.065)	(2.222)
Parent (E)	0.021	0.009	0.012	0.016	0.071	0.110
	(0.036)	(0.009)	(0.014)	(0.018)	(0.064)	(0.116)
Parent (L)	0.008	0.017	0.011	0.016	0.039	0.117
	(0.014)	(0.027)	(0.014)	(0.015)	(0.027)	(0.098)
Current feeling (E)	0.445	0.344	0.346	0.341	0.464	0.397
	(0.052)	(0.130)	(0.119)	(0.188)	(0.152)	(0.263)
Current feeling (L)	0.552	0.448	0.331	0.421	0.522	0.328
	(0.082)	(0.081)	(0.038)	(0.071)	(0.193)	(0.030)
Past feeling (E)	0.013	0.003	0.008	0.010	0.027	0.106
	(0.022)	(0.004)	(0.011)	(0.010)	(0.028)	(0.149)
Past feeling (L)	0.001	0.004	0.013	0.005	0.009	0.032
	(0.002)	(0.004)	(0.022)	(0.004)	(0.008)	(0.045)
Conflict (E)	0.020	0.031	0.027	0.031	0.042	0.081
	(0.010)	(0.030)	(0.013)	(0.013)	(0.028)	(0.076)
Conflict (L)	0.006	0.033	0.021	0.041	0.043	0.036
	(0.006)	(0.018)	(0.008)	(0.017)	(0.023)	(0.005)

The Two Therapy Groupings

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of patient statements in which each transference component was explicitly referred to, the mean number of such references within patient statements, and the rate of such references. These analyses showed a significant increase in the mean number and rate of explicit references to current feelings in late sessions over early ($F(1, 21) = 5.604 = p<0.05$ and $F(1, 21) = 4.485$, $p<0.05$) but no other effect of session order nor of the interaction of session order and type of therapy. The analyses showed significant effects of type of therapy on references to transference components and these replicated the findings from one-way ANOVAs reported above (see page 91).

A series of paired samples t-Tests did not show any effects of session order within the Cognitive-behaviour or within the Psychodynamic grouping of therapies.

The Six Therapy Groups

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared, across the six therapy groups, percentage, mean and rate measures of patient explicit references to transference components. These analyses showed a number of significant effects of session order. There were significant reductions in late sessions over early of the percentage of statements containing references to the therapist ($F (1, 21) = 4.837$, $p<0.01$) and the rate of references to past feelings ($F (1, 21) = 5.329$, $p<0.5$). There were also significant increases in late sessions over early of the percentage of statements containing references to parents ($F (1, 21) = 6.36$, $p<0.05$) and of mean references to the therapist ($F (1, 21) = 5.140$, $p<0.05$) and to past feelings ($F (1, 21) = 5.045$, $p<0.05$).

The analyses also showed significant effects of the interaction of session order and type of therapy on the percentages of statements containing references to the therapist ($F (5, 21) = 5.671$, $p<0.005$) and to parents ($F (5, 21) = 4.326$, $p<0.01$). These interactions were analysed further. Analyses of patient explicit references to the therapist showed significant differences between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the effect of session order ($F (1, 3) = 324.161$, $p<0.001$) and the interaction of session order and type of therapy ($F (1, 3) = 312.00$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher percentage of patient statements containing such references and

a greater decrease in them in late over early sessions of therapy than did the Behaviour therapy group.

ii) the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 126.951$, $p<0.001$) and the interaction of session order and type of therapy ($F(1, 5) = 140.059$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher percentage of patient statements containing explicit references to the therapist in both early and late sessions with both groups seeing a decrease in references to the therapist in late over early sessions of therapy.

iii) the Cognitive therapy group in the effect of session order ($F(1, 4) = 41.987$, $p<0.005$) and the interaction of session order and type of therapy ($F(1, 4) = 32.751$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher percentage of patient statements containing such references in both early and late sessions with both groups seeing a decrease in references to the therapist in late over early sessions of therapy.

iv) the Conversational psychotherapy group in the effect of session order ($F(1, 5) = 32.403$, $p<0.005$) and the interaction of session order and type of therapy ($F(1, 5) = 32.403$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher percentage of statements containing such references in both early and late sessions and which decreased in late over early sessions of therapy whereas in the Conversational psychotherapy group they increased.

Analyses of patient explicit references to parents showed significant differences between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the interaction of session order and therapy type ($F(1, 3) = 12.927$, $p<0.05$) with the Psychoanalytic group having a higher percentage of patient statements containing explicit references to parents, which increased in late over early sessions whereas in the Behaviour therapy group they decreased.

ii) the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 19.515$, $p<0.01$) and the interaction of session order and therapy type ($F(1, 5) = 18.587$, $p<0.01$). The Psychoanalytic psychotherapy group had a higher percentage of patient statements referring explicitly to parents and a higher increase in them in late over early sessions of therapy than the Cognitive-behaviour therapy group.

iii) the Cognitive therapy group in the effect of session order ($F(1, 4) = 18.131$, $p<0.05$) and the interaction of session order and therapy type ($F(1, 4) = 19.207$, $p<0.05$). The Psychoanalytic

psychotherapy group had a higher percentage of patient statements containing such references, which increased in late over early sessions of therapy whereas in the Cognitive therapy group they reduced.

iv) the Conversational psychotherapy group in the effect of session order ($F(1, 5) = 13.381$, $p<0.05$) and the interaction of session order and therapy type ($F(1, 5) = 12.295$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher occurrence of patient statements containing such references and a higher increase in them in late over early sessions of therapy than the Conversational psychotherapy group.

There were significant effects of type of therapy on percentage, mean and rate measures of references to the various transference components and these replicated the findings from one-way ANOVAs reported above (see pages 92-95).

Paired samples t-Tests showed a significant increase in late sessions over early of the Cognitive-behaviour therapy group of the percentage of statements containing references to current feelings ($t(4) = 4.777$, $p<0.01$) and in the rate of such references ($t(4) = 3.170$, $p<0.05$).

Table 5.53. The Number of Different Transference Components Referred To Per Patient Statement (Mean) and Per Patient Line (Rate) Compared Across Early and Late Sessions and the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Mean:				
Explicit	0.698	0.775	1.314	1.405
	(0.179)	(0.148)	(0.394)	(0.444)
Implicit	0.291	0.251	0.715	0.713
	(0.152)	(0.128)	(0.555)	(0.370)
Expl.& Impl.	0.992	1.018	2.005	1.924
	(0.245)	(0.219)	(0.869)	(0.829)
Rate:				
Explicit	0.295	0.321	0.226	0.193
	(0.127)	(0.086)	(0.081)	(0.081)
Implicit	0.111	0.094	0.108	0.087
	(0.051)	(0.032)	(0.038)	(0.030)
Expl.& Impl.	0.407	0.412	0.330	0.264
	(0.149)	(0.078)	(0.098)	(0.114)

Table 5.54. The Number of Different Transference Components Referred To Per Patient Statement (Mean) and Per Patient Line (Rate) Compared Across Early and Late Sessions and the Six Therapy Groups (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
		Cog.-beh.		Conversational		Psychoanalytic
Referent						
Mean:						
Explicit (E)	0.723	0.638	0.755	1.054	1.322	1.945
	(0.223)	(0.157)	(0.202)	(0.191)	(0.298)	(0.078)
Explicit (L)	0.737	0.810	0.760	1.064	1.438	2.195
	(0.179)	(0.142)	(0.167)	(0.035)	(0.206)	(0.078)
Implicit (E)	0.107	0.356	0.348	0.542	0.540	1.500
	(0.012)	(0.152)	(0.090)	(0.156)	(0.184)	(1.174)
Implicit (L)	0.130	0.346	0.223	0.666	0.735	0.785
	(0.096)	(0.113)	(0.079)	(0.252)	(0.578)	(0.304)
Expl.& Impl. (E)	0.827	1.006	1.098	1.592	1.775	3.500
	(0.221)	(0.212)	(0.290)	(0.304)	(0.302)	(1.174)
Expl.& Impl. (L)	0.863	1.144	0.978	1.728	1.703	2.855
	(0.248)	(0.142)	(0.235)	(0.278)	(1.211)	(0.205)
Rate:						
Explicit (E)	0.375	0.208	0.344	0.217	0.226	0.247
	(0.139)	(0.103)	(0.097)	(0.904)	(0.079)	(0.113)
Explicit (L)	0.427	0.259	0.320	0.196	0.196	0.179
	(0.038)	(0.064)	(0.057)	(0.085)	(0.099)	(0.083)
Implicit (E)	0.060	0.106	0.156	0.105	0.089	0.155
	(0.029)	(0.042)	(0.035)	(0.026)	(0.031)	(0.055)
Implicit (L)	0.074	0.107	0.093	0.108	0.075	0.058
	(0.044)	(0.028)	(0.028)	(0.029)	(0.018)	(0.007)
Expl.& Impl. (E)	0.436	0.317	0.499	0.321	0.300	0.411
	(0.176)	(0.111)	(0.137)	(0.113)	(0.086)	(0.071)
Expl.& Impl. (L)	0.497	0.362	0.411	0.304	0.230	0.231
	(0.029)	(0.056)	(0.079)	(0.093)	(0.154)	(0.100)

Patient Explicit References in Early Sessions and in Late Sessions Across the Six Therapy Groups

A series of one-way ANOVAs showed a significant overall effect of type of therapy in early sessions and in late sessions of the six therapy groups on percentage, mean and rate measures of patient explicit references to the therapist, to parents and to conflict. A priori contrasts showed the Psychodynamic psychotherapy group tended to contain a higher level of these references than the

Behaviour, Cognitive-behaviour and Cognitive therapy groups and the Psychoanalytic psychotherapy group higher levels than the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. These results are presented in full in Appendix 8.

ii) Patient Implicit Reference to Individual Transference Components

The percentage of patient statements within sessions in which each of the five potential references to transference components were implicitly referred to was analysed across early and late sessions and type of therapy. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.55. The results of this analysis across the six therapy groups is presented in Table 5.56.

The number of implicit references in each patient statement to the five transference component was also analysed. The results of this analysis across the Cognitive-behaviour and Psychodynamic therapies is presented in Table 5.57. The results of the analysis across the six therapies is presented in Table 5.58.

The rate of patient references to each of the transference components was also analysed. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.59. These rates analysed across the six therapy groups are presented in Table 5.60.

The number of different transference components referred to implicitly in each patient statement and per line of patient statement were also analysed. The results of these analyses across the Cognitive-behaviour and Psychodynamic therapies are presented in Table 5.53. The results of the analyses across the six therapy groups are presented in Table 5.54.

This section of analyses includes testing of the hypotheses that:

i) patients' implicit references to transference components will be lower in late than in early sessions of the Psychodynamic grouping of therapies and higher in the Cognitive-behaviour grouping of therapies

ii) patients' implicit references to transference components will be lower in late than in early sessions of the Psychoanalytic and Psychodynamic psychotherapy groups and higher in the Behaviour, Cognitive-behaviour and Cognitive therapy groups

Table 5.55. Percentage of patient statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which each transference component was implicitly identified (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	17.72	17.19	29.88	29.67
	(11.65)	(11.92)	(14.01)	(15.73)
Parent	2.45	1.81	12.49	12.64
	(2.39)	(6.84)	(18.29)	(12.84)
Current feeling	5.07	3.44	14.71	14.35
	(2.21)	(5.30)	(18.10)	(19.07)
Past feeling	4.71	2.73	12.73	12.65
	(4.24)	(8.79)	(9.18)	(13.43)
Conflict	8.05	9.08	28.25	17.85
	(4.17)	(5.23)	(25.26)	(16.95)

Table 5.56. Percentage of patient statements across early and late sessions and type of therapy in which each of the 10 transference components were implicitly identified (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Referent					
Therapist (E)	5.00	23.04	20.60	26.02	24.65	50.00
	(0.52)	(14.34)	(1.79)	(5.14)	(10.12)	(23.62)
Therapist (L)	9.13	21.56	17.78	32.48	27.60	26.80
	(7.89)	(10.08)	(4.90)	(11.76)	(20.25)	(2.55)
Parent (E)	0.20	3.10	3.33	7.10	6.03	38.90
	(0.35)	(2.37)	(2.55)	(4.55)	(1.92)	(39.32)
Parent (L)	0.00	3.78	0.70	11.18	13.63	14.30
	(0.00)	(2.02)	(0.81)	(9.82)	(11.76)	(20.22)
Current feeling (E)	4.67	4.62	5.93	9.18	6.75	44.45
	(1.04)	(1.94)	(3.26)	(4.02)	(3.93)	(31.47)
Current feeling (L)	3.77	4.08	2.40	11.08	13.10	25.00
	(2.17)	(1.43)	(2.75)	(7.00)	(11.26)	(35.36)
Past feeling (E)	0.97	6.80	4.90	12.42	11.15	16.65
	(1.67)	(4.83)	(3.40)	(7.22)	(3.56)	(23.55)
Past feeling (L)	0.00	5.48	1.33	13.70	17.65	0.00
	(0.00)	(3.60)	(0.65)	(13.15)	(12.74)	(0.00)
Conflict (E)	6.80	6.30	11.20	16.00	24.38	66.65
	(1.32)	(2.41)	(5.95)	(6.82)	(8.39)	(47.16)
Conflict (L)	7.47	10.10	9.00	15.78	25.78	7.15
	(4.48)	(5.54)	(2.35)	(8.66)	(17.04)	(10.11)

Table 5.57. The mean number of implicit references in a patient statement to each transference component across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.198	0.205	0.461	0.447
	(0.132)	(0.151)	(0.252)	(0.276)
Parent	0.025	0.020	0.166	0.173
	(0.026)	(0.024)	(0.280)	(0.162)
Current feeling	0.051	0.039	0.190	0.166
	(0.022)	(0.028)	(0.214)	(0.166)
Past feeling	0.052	0.027	0.171	0.216
	(0.052)	(0.033)	(0.181)	(0.264)
Conflict	0.142	0.101	0.364	0.245
	(0.206)	(0.053)	(0.350)	(0.191)

Table 5.58. The mean number of implicit references in a patient statement to each transference component across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
		Cog.-beh.		Conversational		Psychoanalytic
Referent						
Therapist (E)	0.051	0.272	0.215	0.358	0.375	0.890
	(0.005)	(0.155)	(0.019)	(0.088)	(0.207)	(0.156)
Therapist (L)	0.092	0.290	0.185	0.478	0.523	0.270
	(0.079)	(0.197)	(0.050)	(0.208)	(0.213)	(0.028)
Parent (E)	0.002	0.033	0.033	0.078	0.082	0.555
	(0.003)	(0.028)	(0.026)	(0.053)	(0.047)	(0.629)
Parent (L)	0.000	0.042	0.007	0.152	0.384	0.145
	(0.000)	(0.022)	(0.008)	(0.154)	(0.321)	(0.205)
Current feeling (E)	0.048	0.046	0.059	0.104	0.085	0.615
	(0.013)	(0.019)	(0.033)	(0.047)	(0.027)	(0.078)
Current feeling (L)	0.038	0.050	0.027	0.126	4.050	0.250
	(0.022)	(0.029)	(0.033)	(0.083)	(0.983)	(0.354)
Past feeling (E)	0.010	0.079	0.049	0.136	0.133	0.335
	(0.017)	(0.065)	(0.034)	(0.080)	(0.058)	(0.474)
Past feeling (L)	0.000	0.055	0.014	0.194	0.107	0.000
	(0.000)	(0.036)	(0.007)	(0.238)	(0.113)	(0.000)
Conflict (E)	0.301	0.070	0.113	0.172	0.315	0.945
	(0.415)	(0.031)	(0.061)	(0.079)	(0.101)	(0.544)
Conflict (L)	0.076	0.125	0.091	0.176	0.384	0.145
	(0.048)	(0.070)	(0.024)	(0.613)	(0.253)	(0.205)

Table 5.59. The rate of implicit references to individual transference components across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.072	0.075	0.074	0.060
	(0.038)	(0.039)	(0.030)	(0.038)
Parent	0.008	0.006	0.020	0.019
	(0.008)	(0.007)	(0.022)	(0.014)
Current feeling	0.023	0.016	0.028	0.018
	(0.016)	(0.012)	(0.027)	(0.012)
Past feeling	0.016	0.009	0.024	0.023
	(0.013)	(0.010)	(0.015)	(0.023)
Conflict	0.078	0.039	0.054	0.035
	(0.154)	(0.014)	(0.032)	(0.028)

Table 5.60. The rate of patient implicit references to individual transference components across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Referent					
Therapist (E)	0.030	0.076	0.100	0.072	0.058	0.109
	(0.017)	(0.036)	(0.024)	(0.025)	(0.025)	(0.036)
Therapist (L)	0.050	0.088	0.078	0.085	0.048	0.023
	(0.032)	(0.053)	(0.017)	(0.042)	(0.017)	(0.013)
Parent (E)	0.001	0.009	0.013	0.013	0.014	0.051
	(0.001)	(0.006)	(0.009)	(0.008)	(0.009)	(0.045)
Parent (L)	0.000	0.012	0.003	0.020	0.019	0.016
	(0.000)	(0.005)	(0.004)	(0.016)	(0.011)	(0.023)
Current feeling (E)	0.031	0.017	0.026	0.021	0.014	0.076
	(0.021)	(0.013)	(0.016)	(0.013)	(0.005)	(0.029)
Current feeling (L)	0.023	0.016	0.011	0.018	0.019	0.013
	(0.015)	(0.009)	(0.012)	(0.012)	(0.014)	(0.019)
Past feeling (E)	0.002	0.021	0.021	0.023	0.022	0.028
	(0.004)	(0.014)	(0.010)	(0.009)	(0.011)	(0.039)
Past feeling (L)	0.000	0.018	0.006	0.025	0.032	0.000
	(0.000)	(0.011)	(0.003)	(0.026)	(0.019)	(0.000)
Conflict (E)	0.210	0.022	0.050	0.034	0.054	0.104
	(0.306)	(0.010)	(0.028)	(0.014)	(0.025)	(0.010)
Conflict (L)	0.043	0.038	0.038	0.030	0.049	0.016
	(0.018)	(0.017)	(0.010)	(0.013)	(0.042)	(0.023)

The Two Therapy Groupings

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of patient statements in which each transference component was implicitly referred to, the mean number of such references within patient statements, and the rate of such references. These analyses showed no significant effect of session order or of the interaction of session order and type of therapy but did show significant effects of type of therapy on references to transference components and these replicated the findings from one-way ANOVAs reported above (see pages 97-98). The analyses also showed no significant effect of session order or of the interaction of session order and type of therapy on the total number of different individual transference components implicitly, and explicitly and implicitly, referred to in patient statements and per line of patient statements.

Paired samples t-Test showed no significant effect of session order within the Cognitive-behaviour or within the Psychodynamic grouping of therapies.

The Six Therapy Groups

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared, across the six therapy groups, percentage, mean and rate measures of patient implicit references to transference components. The analyses showed a number of significant effects of session order. The percentage of statements containing implicit references to conflict and the mean of these references were significantly lower in late sessions of therapy over early ($F(1, 17) = 6.143$, $p<0.05$ and ($F(1, 17) = 5.045$, $p<0.05$), as was the rate of implicit references to current feeling ($F(1,17) = 9.492$, $p<0.01$).

The analyses also showed significant effects of the interaction of session order and type of therapy on the percentages of statements containing references to conflict ($F(5, 17) = 4.559$, $p<0.001$) and to current feeling ($F(5, 17) = 4.59$, $p<0.01$), the mean number of references to the therapist ($F(5, 17) = 3.283$, $p<0.05$), to current feeling ($F(5, 17) = 4.657$, $p<0.01$) and to conflict ($F(5, 17) = 3.841$, $p<0.05$) and the rate of references to the therapist ($F(5, 17) = 5.001$, $p<0.005$) and to current feelings ($F(5, 17) = 3.407$, $p<0.05$). These interactions were analysed further.

Analysis of the percentage of patient statements containing implicit references to conflict showed a significant difference between the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 6.607$, $p<0.5$) and in the interaction of session order and therapy type ($F(1, 5) = 8.533$, $p<0.05$). The Psychoanalytic

psychotherapy group had a higher occurrence of such references in early sessions which then significantly decreased in late sessions to a level lower than in the Cognitive-behaviour group whose references increased over those in its early sessions.

Analysis of the percentage of patient statements containing implicit references to current feeling showed a significant difference between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the effect of session order ($F(1, 3) = 80.564$, $p<0.005$) and in the interaction of session order and therapy type ($F(1, 3) = 66.942$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher occurrence of such references in both early and late sessions. These references then decreased in late sessions of both groups.

ii) the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 149.776$, $p<0.001$) and in the interaction of session order and therapy type ($F(1, 5) = 134.030$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher occurrence of such references in both early and late sessions. The references decreased in late sessions of both groups.

iii) the Cognitive therapy group in the effect of session order ($F(1, 4) = 23.607$, $p<0.01$) and in the interaction of session order and therapy ($F(1, 4) = 11.342$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher occurrence of such references in both early and late sessions. These references then decreased in late sessions of both groups.

Analysis of the mean of patient implicit references to the therapist showed a significant difference between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the effect of session order ($F(1, 3) = 26.840$, $p<0.05$) and in the interaction of session order and therapy type ($F(1, 3) = 34.906$, $p<0.01$). The Psychoanalytic psychotherapy group had a higher occurrence of references than the Behaviour therapy group in both early and late sessions with the references decreasing in late over early sessions of the Psychoanalytic group whereas they increased in the Behaviour therapy group.

ii) the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 14.887$, $p<0.05$) and in the interaction of session order and therapy type ($F(1, 5) = 16.721$, $p<0.01$). The Psychoanalytic psychotherapy group had a higher occurrence of references in early sessions than the Cognitive-behaviour therapy group. However these sessions then decreased in late over early sessions whereas they increased in the Cognitive-behaviour therapy group. Thus in late sessions

the Cognitive-behaviour group had a higher level of references than did the Psychoanalytic psychotherapy group.

iii) the Cognitive therapy group in the effect of session order ($F(1, 4) = 49.633$, $p<0.005$) and in the interaction of session order and therapy type ($F(1, 4) = 40.893$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher occurrence of references than the Behaviour therapy group in both early and late sessions with the references decreasing in late over early sessions of both groups.

Analysis of the mean of patient implicit references to current feeling showed a significant difference between the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 12.054$, $p<0.05$) and in the interaction of session order and type of therapy group ($F(1, 5) = 12.567$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher occurrence of references than the Cognitive-behaviour therapy group in both early and late sessions with the references decreasing in late over early sessions of the Psychoanalytic group whereas they increased in the Cognitive-behaviour therapy group.

Analysis of the mean number of patient implicit references to conflict showed a significant difference between the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 6.934$, $p< 0.05$) and in the interaction of session order and therapy type ($F(1, 5) = 9.124$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher occurrence of references than the Cognitive-behaviour therapy group in both early and late sessions with the references decreasing in late over early sessions of the Psychoanalytic group whereas they increased in the Cognitive-behaviour therapy group.

Analysis of the rate of patient implicit references to the therapist showed a significant difference between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the effect of session order ($F(1, 3) = 14.978$, $p<0.05$) and in the interaction of session order and therapy type ($F(1, 3) = 37.291$, $p<0.01$). The Psychoanalytic psychotherapy group had a higher rate of implicit references to the therapist than the Behaviour therapy group in early sessions. The rate of references then decreased in late over early sessions of the Psychoanalytic group whereas they increased in the Behaviour therapy group to a level higher than the Psychoanalytic in late sessions.

ii) the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 7.911$, $p<0.05$) and in the interaction of session order and therapy type ($F(1, 5) = 13.903$, $p<0.05$). The

Psychoanalytic psychotherapy group had a higher rate of implicit references to the therapist than the Cognitive-behaviour therapy group in early sessions. The rate of references then decreased in late over early sessions of the Psychoanalytic group whereas they increased in the Cognitive-behaviour therapy group to a level higher than the Psychoanalytic in late sessions.

iii) the Cognitive therapy group in the effect of session order ($F(1, 4) = 38.271$, $p<0.005$) and in the interaction of session order and therapy type ($F(1, 4) = 13.246$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher rate occurrence of implicit references to the therapist than the Cognitive-behaviour therapy group in early sessions. The rate of references then decreased in late over early sessions of both groups but less so in the Cognitive group so that it had a higher rate than the Psychoanalytic in late sessions.

Analysis of the rate of patient implicit references current feelings showed a significant difference between the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 11.232$, $p<0.05$) and the effect of the interaction of session order and therapy ($F(1, 5) = 10.886$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher rate of implicit references to current feelings in early sessions of therapy than the Cognitive-behaviour therapy group. Both groups saw a decrease in the rate of references in late over early sessions of therapy, the Psychoanalytic group more so than in the Cognitive-behaviour therapy group so that the latter had a higher rate of references in late sessions.

A significant effect of session order and of the interaction of session order and type of therapy was also obtained on the number of different transference components implicitly referred to per line of patient narrative ($F(1,17) = 12.077$, $p<0.005$ and $F(5, 17) = 4.750$, $p<0.01$). Further analysis showed a significant difference between the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 10.126$, $p<0.05$) and in the effect of the interaction of session order and therapy type ($F(1, 5) = 10.655$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher rate of the total number of different transference components implicitly referred to in early sessions of therapy than the Cognitive-behaviour therapy group. These then decreased in late over early sessions of Psychoanalytic psychotherapy whereas in the Cognitive-behaviour therapy group they increased so that in late sessions the Cognitive-behaviour group had a higher rate.

There were significant effects of type of therapy on percentage, mean and rate measures of references to the various transference components and these replicated findings from one-way ANOVAs reported above (see pages 98 -100).

A paired samples t-Test showed a significant increase in late sessions over early of the Cognitive-behaviour therapy group of the rate of references to conflict ($t(4) = 2.925$, $p<0.05$).

There were no other significant effects of session order or the interaction of session order and type of therapy on patient explicit and patient implicit references to transference components.

Summary

Patient references to transference components across early and late sessions

Support was not obtained for the hypotheses that patient explicit references to individual transference components would be higher in late sessions of therapy than early:

i) overall, with the exception of references to current feelings, no individual transference component was explicitly referred to more in late sessions than in early

ii) analysis across the two therapy groupings showed neither contained higher explicit references to any transference component in late over early sessions

iii) analysis across the six therapy groups showed the Cognitive-behaviour group to have a higher occurrence of explicit references to current feelings in late over early sessions

iv) analysis across the six therapy groups also provided some support for explicit references to parents tending to increase in late sessions over early except in the Behaviour and Cognitive therapy groups. These references tended to be highest, and increase most in late sessions, in the Psychoanalytic group.

The total number of different types of transference components explicitly referred to in patient statements increased in late sessions over early of both the Cognitive-behaviour and Psychodynamic grouping of therapies. The increases however were not significant.

Partial support was obtained for the hypothesis that patient explicit references to individual transference components in early sessions would be higher in the Psychodynamic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. In fact references to the therapist and to parents tended to be higher than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups and references to conflict higher than in the Behaviour and Cognitive therapy groups.

Partial support was also obtained for the hypothesis that patient explicit references to individual transference components in late sessions would be higher in the Psychodynamic psychotherapy

group than in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. In fact references to conflict were higher than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups and there was some evidence that references to the therapist and to parents were higher than in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups.

Partial support was obtained for the hypothesis that patient explicit references to individual transference components in early sessions would be higher in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. In fact references to the therapist, parents and conflict were higher.

Partial support was obtained for the hypothesis that patient explicit references to individual transference components in late sessions would be higher in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. In fact references to parents and to conflict were higher and there was some evidence that references to the therapist were higher than in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was not obtained for the hypotheses that patient implicit references to individual transference components would be higher in late sessions over early of the Cognitive-behaviour grouping of therapies.

Support was not obtained for the hypotheses that patient implicit references to individual transference components would be lower in late sessions over early of the Psychodynamic grouping of therapies.

Implicit references to the therapist tended to increase in late sessions over early of the Behaviour and Cognitive-behaviour therapy groups and decrease in the Psychoanalytic. The references tended to be highest, and to decrease most in late sessions, in the Psychoanalytic group.

Implicit references to current feelings tended to increase in late sessions over early of the Psychodynamic psychotherapy group and decrease in the Behaviour, Cognitive and Psychoanalytic therapy groups.

Some support was obtained for implicit references to conflict increasing in late over early sessions of the Cognitive-behaviour therapy group.

Implicit references to conflict tended to increase in late over early sessions of Cognitive-behaviour therapy and decrease in Psychoanalytic psychotherapy. The total number of different types of transference components implicitly referred to in patient statements was lower in late sessions over early of the Psychodynamic grouping of therapies but this was not significant. They were also lower in the Cognitive-behaviour grouping, again this not being significant.

The total number of different types of transference components implicitly referred to in patient statements tended to increase in late over early sessions of the Behaviour, Cognitive-behaviour and Conversational groups and decrease in the Cognitive and Psychoanalytic.

iii) Therapist Explicit Reference to Individual Transference Components

The percentage of therapist statements within sessions in which explicit references to each of the five transference components were made was analysed across early and late sessions and type of therapy. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.61. The results of this analysis across the six therapy groups is presented in Table 5.62.

The number of explicit references in each therapist statement to the five transference components was analysed across early and late sessions and type of therapy. The results of this analysis across the Cognitive-behaviour and Psychodynamic therapies is presented in Table 5.63. The results of the analysis across the six therapies is presented in Table 5.64.

The rate of therapists' explicit references to each of the transference components was also analysed. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.65. These rates analysed across the six therapy groups are presented in Table 5.66.

The number of different transference components referred to in each therapist statement and per line of therapist statement were also analysed. The results of these analyses across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.67. These rates analysed across the six therapy groups are presented in Table 5.68.

This section of analyses includes testing of the hypotheses that:

i) therapists' explicit references to themselves will increase in late over early sessions of the Psychodynamic psychotherapy group as they increasingly focus in this short term dynamic therapy on the patient-therapist relationship. The references will be higher in both early and late sessions than those in the Behaviour, Cognitive-behaviour and Cognitive therapy groups

ii) therapists' explicit references to themselves will not increase in the Psychoanalytic psychotherapy group as they will be high from the beginning. The references will be higher in both early and late sessions than those in the Behaviour, Cognitive-behaviour and Cognitive therapy groups

iii) therapists' explicit references to parents will increase in late over early sessions of the Psychoanalytic psychotherapy group as genetic transference interpretations increase. There will not be an increase in any other groups

The Two Therapy Groupings

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements in which each transference component was explicitly referred to, the mean number of such references within therapist statements, and the rate of such references. These analyses showed no significant effect of session order or of the interaction of session order and type of therapy but did show significant effects of type of therapy on references to transference components and these replicated the findings from one-way ANOVAs reported above (see page 107). The analyses also showed no significant effect of session order or of the interaction of session order and type of therapy on the total number of different individual transference components explicitly to in patient statements and per line of patient statements.

Paired samples t-Tests showed no significant effect of session order within the Cognitive-behaviour or within the Psychodynamic grouping of therapies.

Table 5.61. Percentage of therapist statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which each transference component was explicitly identified (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	2.83	2.65	16.69	24.10
	(2.86)	(8.16)	(13.01)	(11.91)
Parent	0.93	1.92	12.82	14.31
	(1.41)	(3.24)	(13.71)	(14.72)
Current feeling	43.60	43.17	66.29	67.80
	(15.91)	(18.12)	(12.95)	(11.88)
Past feeling	0.58	0.09	4.98	3.60
	(1.63)	(2.06)	(4.89)	(5.57)
Conflict	3.28	2.13	10.10	14.16
	(4.09)	(5.72)	(8.57)	(9.28)

Table 5.62. Percentage of therapist statements across early and late sessions in which each of the 10 transference components were explicitly identified (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
		Cog.-beh.		Conversational		Psychoanalytic
Referent						
Therapist (E)	0.60	2.22	5.25	13.16	12.80	33.30
	(0.01)	(0.69)	(3.99)	(13.22)	(10.33)	(3.89)
Therapist (L)	1.20	2.36	4.10	16.30	32.50	26.80
	(0.66)	(1.23)	(5.37)	(8.65)	(14.82)	(2.55)
Parent (E)	0.20	0.74	1.73	5.68	19.83	16.65
	(0.35)	(1.09)	(2.06)	(6.53)	(14.98)	(23.55)
Parent (L)	0.30	2.28	2.68	4.02	18.25	32.15
	(0.52)	(3.96)	(2.82)	(3.79)	(7.93)	(25.24)
Current feeling (E)	23.00	49.64	51.50	69.30	59.55	72.25
	(6.58)	(11.96)	(11.83)	(12.99)	(14.64)	(7.85)
Current feeling (L)	23.07	53.86	44.88	70.02	65.90	66.05
	(7.62)	(10.80)	(1.22)	(9.02)	(13.49)	(12.66)
Past feeling (E)	0.00	0.12	1.60	3.70	6.30	5.55
	(0.00)	(0.27)	(2.75)	(7.49)	(6.14)	(7.85)
Past feeling (L)	0.00	0.00	0.28	2.28	7.05	0.00
	(0.00)	(0.00)	(0.55)	(3.52)	(5.44)	(0.00)
Conflict (E)	0.07	4.72	3.90	7.34	10.28	16.65
	(0.12)	(5.46)	(2.69)	(2.71)	(2.99)	(23.55)
Conflict (L)	0.17	2.78	2.78	8.18	15.33	26.80
	(0.29)	(4.06)	(2.09)	(8.66)	(9.11)	(2.55)

Table 5.63. The mean number of explicit references in a therapist statement to each transference component across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.030	0.027	2.250	0.265
	(0.033)	(0.031)	(6.883)	(0.131)
Parent	0.009	0.021	0.157	0.159
	(0.014)	(0.034)	(0.169)	(0.150)
Current feeling	0.505	0.510	0.788	0.854
	(0.198)	(0.232)	(0.170)	(0.205)
Past feeling	0.006	0.001	0.054	0.042
	(0.016)	(0.003)	(0.055)	(0.054)
Conflict	0.033	0.025	0.117	0.159
	(0.041)	(0.040)	(0.102)	(0.127)

Table 5.64. The mean number of explicit references in a therapist statement to each transference component across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
	Cog.-beh.		Conversational		Psychoanalytic	
Referent						
Therapist (E)	0.006	0.022	0.058	0.144	0.584	0.330
	(0.001)	(0.007)	(0.046)	(0.161)	(1.439)	(0.001)
Therapist (L)	0.012	0.024	0.041	0.184	0.363	0.270
	(0.007)	(0.011)	(0.054)	(0.090)	(0.150)	(0.028)
Parent (E)	0.002	0.007	0.017	0.071	0.261	0.165
	(0.003)	(0.011)	(0.021)	(0.082)	(0.203)	(0.233)
Parent (L)	0.003	0.026	0.027	0.047	0.219	0.320
	(0.005)	(0.047)	(0.028)	(0.045)	(0.090)	(0.255)
Current feeling (E)	0.237	0.586	0.605	0.844	0.750	0.725
	(0.070)	(0.150)	(0.188)	(0.182)	(0.202)	(0.778)
Current feeling (L)	0.247	0.660	0.520	0.904	0.853	0.730
	(0.078)	(0.253)	(0.041)	(0.192)	(0.275)	(0.028)
Past feeling (E)	0.000	0.001	0.016	0.040	0.071	0.055
	(0.000)	(0.003)	(0.028)	(0.035)	(0.077)	(0.078)
Past feeling (L)	0.000	0.000	0.003	0.023	0.086	0.000
	(0.000)	(0.000)	(0.006)	(0.035)	(0.059)	(0.000)
Conflict (E)	0.001	0.047	0.039	0.073	0.157	0.165
	(0.001)	(0.054)	(0.027)	(0.027)	(0.100)	(0.233)
Conflict (L)	0.002	0.036	0.028	0.116	0.157	0.270
	(0.003)	(0.059)	(0.021)	(0.158)	(0.094)	(0.028)

Table 5.65. The rate of therapist explicit references to individual transference components across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.010	0.009	1.487	0.132
	(0.008)	(0.008)	(4.593)	(0.067)
Parent	0.003	0.006	0.091	0.095
	(0.004)	(0.010)	(0.106)	(0.115)
Current feeling	0.181	0.183	0.423	0.412
	(0.035)	(0.059)	(0.118)	(0.108)
Past feeling	0.002	0.001	0.032	0.020
	(0.002)	(0.001)	(0.037)	(0.027)
Conflict	0.011	0.006	0.071	0.082
	(0.015)	(0.007)	(0.087)	(0.072)

Table 5.66. The rate of therapist explicit references to individual transference components across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
	Cog.-beh.	Conversational		Psychoanalytic	
Referent					
Therapist (E)	0.004	0.008	0.016	0.061	3.876	0.273
	(0.001)	(0.004)	(0.012)	(0.063)	(7.638)	(0.035)
Therapist (L)	0.008	0.008	0.011	0.072	0.171	0.201
	(0.005)	(0.006)	(0.013)	(0.035)	(0.044)	(0.002)
Parent (E)	0.002	0.002	0.004	0.030	0.151	0.124
	(0.003)	(0.003)	(0.005)	(0.035)	(0.117)	(0.175)
Parent (L)	0.002	0.008	0.007	0.020	0.112	0.249
	(0.003)	(0.014)	(0.007)	(0.021)	(0.053)	(0.214)
Current feeling (E)	0.167	0.189	0.181	0.364	0.408	0.603
	(0.024)	(0.027)	(0.054)	(0.021)	(0.108)	(0.141)
Current feeling (L)	0.159	0.206	0.171	0.358	0.412	0.548
	(0.047)	(0.078)	(0.036)	(0.086)	(0.099)	(0.073)
Past feeling (E)	0.000	0.001	0.004	0.017	0.042	0.050
	(0.000)	(0.001)	(0.007)	(0.014)	(0.045)	(0.070)
Past feeling (L)	0.000	0.000	0.001	0.008	0.045	0.000
	(0.000)	(0.000)	(0.001)	(0.013)	(0.030)	(0.000)
Conflict (E)	0.001	0.016	0.011	0.032	0.081	0.149
	(0.001)	(0.022)	(0.008)	(0.009)	(0.060)	(0.210)
Conflict (L)	0.001	0.008	0.008	0.040	0.073	0.201
	(0.002)	(0.009)	(0.005)	(0.046)	(0.041)	(0.002)

The Six Therapy Groups

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared, across the six therapy groups, percentage, mean and rate measures of therapist explicit references to transference components. The analyses showed significant effects of the interaction of session order and type of therapy on the percentage of statements containing references to the therapist ($F(5, 17) = 4.503$, $p<0.01$) and on the rate of references to parents ($F(5, 17) = 3.136$, $p<0.05$). These interactions were analysed further.

Analysis of the percentage of therapist statements containing explicit references to themselves showed significant differences between:

i) the Psychoanalytic psychotherapy group and the Behaviour therapy group in the effect of session order ($F(1, 3) = 17.073$, $p< 0.05$) and in the interaction of session order and therapy type ($F(1, 3) = 24.724$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher percentage of statements containing explicit references to the therapist than the Behaviour therapy group in both early and late sessions with the percentage decreasing in late over early sessions of the Psychoanalytic group whereas it increased in the Behaviour therapy group.

ii) the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 27.278$, $p< 0.005$) and in the interaction of session order and therapy type ($F(1, 5) = 29.732$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher percentage of statements containing explicit references to the therapist than the Cognitive-behaviour therapy group in both early and late sessions with the percentage decreasing in late over early sessions of the Psychoanalytic group whereas it increased in the Cognitive-behaviour therapy group.

iii) the Psychodynamic psychotherapy group and the Cognitive-behaviour therapy group in the effect of session order ($F(1, 7) = 10.968$, $p< 0.05$) and in the interaction of session order and therapy type ($F(1, 7) = 10.661$, $p<0.05$). The Psychodynamic psychotherapy group had a higher percentage of statements containing explicit references to the therapist than did the Cognitive-behaviour therapy group in both early and late sessions with the percentage increasing in late over early sessions of both therapy groups.

Analysis of the rate of therapists' explicit references to parents showed significant differences between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the effect of session order ($F(1, 3) = 37.062$, $p<0.01$) and in the interaction of session order and therapy type ($F(1, 3) = 37.259$, $p<0.01$). The Psychoanalytic psychotherapy group had a higher rate of explicit references to parents than the Behaviour therapy group in both early and late sessions of therapy. The rate of references increased in late over early sessions of the Psychoanalytic group whereas they decreased in the Behaviour therapy group.

ii) the Cognitive-behaviour therapy group in the effect of session order ($F(1, 5) = 49.351$, $p<0.001$) and in the interaction of session order and therapy type ($F(1, 5) = 40.676$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher rate of explicit references to parents than the Cognitive-behaviour therapy group in both early and late sessions of therapy. The rate of references increased in late over early sessions of both groups.

iii) the Cognitive therapy group in the effect of session order ($F(1, 4) = 49.914$, $p<0.005$) and in the interaction of session order and therapy type ($F(1, 4) = 45.839$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher rate of explicit references to parents than the Cognitive therapy group in both early and late sessions of therapy. The rate of references increased in late over early sessions of both groups.

iv) the Conversational psychotherapy group in the effect of session order ($F(1, 5) = 8.712$, $p<0.05$) and in the interaction of session order and therapy ($F(1, 5) = 12.028$, $p<0.05$). The Psychoanalytic psychotherapy group had a higher rate of explicit references to parents than the Conversational group in both early and late sessions of therapy. The rate of references increased in late over early sessions of the Psychoanalytic group and decreased in the Conversational group.

The analyses also showed significant effects of type of therapy on references to transference components and these replicated the findings from one-way ANOVAs reported above (see pages 108-112). In addition, a paired samples t-Test showed the Psychoanalytic psychotherapy group to contain a higher percentage of statements in late sessions over early containing explicit references to parents ($t(1) = 12.917$, $p<0.05$).

Table 5.67. The Number of Different Transference Components Referred To Per Therapist Statement (Mean) and Per Therapist Line (Rate) Compared Across Early and Late Sessions and the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Mean:				
Explicit	0.476	0.478	1.008	1.093
	(0.175)	(0.163)	(0.198)	(0.227)
Implicit	0.111	0.112	0.191	0.223
	(0.087)	(0.095)	(0.102)	(0.150)
Expl.& Impl.	0.584	0.588	1.209	1.319
	(0.244)	(0.246)	(0.218)	(0.278)
Rate:				
Explicit	0.172	0.177	0.570	0.562
	(0.031)	(0.058)	(0.259)	(0.260)
Implicit	0.034	0.037	0.097	0.094
	(0.026)	(0.030)	(0.052)	(0.060)
Expl.& Impl.	0.205	0.213	0.676	0.657
	(0.044)	(0.079)	(0.289)	(0.239)

Therapist Explicit References in Early Sessions and in Late Sessions Across the Six Therapy Groups

A series of one-way ANOVAs showed a significant overall effect of type of therapy in early sessions and in late sessions of the six therapy groups on percentage, mean and rate measures of therapist explicit references to the themselves. A priori contrasts showed that in early sessions the Psychoanalytic psychotherapy group contained a higher level of these references than the Cognitive-behaviour and Cognitive therapy groups and that in late sessions the Psychoanalytic and Psychodynamic psychotherapy groups contained a higher level of them than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. These results are presented in full in Appendix 8.

There were no other significant effects of session order, type of therapy or the interaction of session order and type of therapy on therapist explicit references to transference components.

Table 5.68. The Number of Different Transference Components Referred To Per Therapist Statement (Mean) and Per Therapist Line (Rate) Compared Across Early and Late Sessions and the Six Therapy Groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referent						
Mean:						
Explicit (E)	0.237	0.518	0.603	0.920	0.985	1.275
	(0.067)	(0.116)	(0.099)	(0.222)	(0.039)	(0.078)
Explicit (L)	0.247	0.584	0.520	0.918	1.233	1.250
	(0.075)	(0.091)	(0.090)	(0.105)	(0.148)	(0.354)
Implicit (E)	0.005	0.138	0.155	0.234	0.177	0.110
	(0.002)	(0.095)	(0.025)	(0.079)	(0.104)	(0.156)
Implicit (L)	0.020	0.141	0.145	0.244	0.308	0.000
	(0.018)	(0.115)	(0.063)	(0.118)	(0.113)	(0.000)
Expl.& Impl. (E)	0.240	0.650	0.760	1.152	1.163	1.455
	(0.062)	(0.170)	(0.167)	(0.268)	(0.087)	(0.163)
Expl.& Impl. (L)	0.260	0.720	0.668	1.168	1.543	1.250
	(0.087)	(0.191)	(0.150)	(0.188)	(0.247)	(0.354)
Rate:						
Explicit (E)	0.167	0.169	0.178	0.397	0.547	1.050
	(0.020)	(0.038)	(0.037)	(0.062)	(0.115)	(0.070)
Explicit (L)	0.160	0.194	0.169	0.373	0.603	0.950
	(0.049)	(0.083)	(0.023)	(0.121)	(0.041)	(0.354)
Implicit (E)	0.004	0.044	0.045	0.101	0.090	0.099
	(0.002)	(0.030)	(0.005)	(0.024)	(0.039)	(0.140)
Implicit (L)	0.013	0.044	0.046	0.089	0.146	0.000
	(0.012)	(0.040)	(0.016)	(0.024)	(0.041)	(0.000)
Expl.& Impl. (E)	0.170	0.211	0.224	0.497	0.637	1.203
	(0.016)	(0.055)	(0.035)	(0.063)	(0.076)	(0.287)
Expl.& Impl. (L)	0.168	0.237	0.215	0.466	0.750	0.950
	(0.055)	(0.112)	(0.036)	(0.117)	(0.032)	(0.354)

iv) Therapist Implicit Reference to Individual Transference Components

The percentage of therapist statements within sessions in which implicit references to each of the five transference components were made was analysed across early and late sessions and type of therapy. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.69. The results of this analysis across the six therapy groups is presented in Table 5.70.

The number of implicit references in each therapist statement to the five transference components was analysed across early and late sessions and type of therapy. The results of this analysis across the Cognitive-behaviour and Psychodynamic therapies is presented in Table 5.71. The results of the analysis across the six therapies is presented in Table 5.72.

The rate of therapists' implicit references to each of the transference components was also analysed. The results of this analysis across the two groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, are presented in Table 5.73. These rates analysed across the six therapy groups are presented in Table 5.74.

This section of analyses includes testing of the hypotheses that:

i) the total number of different transference components implicitly referred to in therapists' statements will increase in late over early sessions of the Behaviour, Cognitive-behaviour and Cognitive therapy groups

ii) the total number of different transference components implicitly referred to in therapists' statements will decrease in late over early sessions of the Psychodynamic and Psychoanalytic psychotherapy groups

iii) the total number of different transference components implicitly referred to in therapists' statements will be higher in late sessions of the Behaviour, Cognitive-behaviour and Cognitive therapy groups than in late sessions of the Psychodynamic and Psychoanalytic psychotherapy groups.

The Two Therapy Groupings

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements in which each transference component was implicitly referred to, the mean number of such references within therapist statements, and the rate of such references. These analyses showed no significant effect of session order or of the interaction of session order and type of therapy. They did however show significant effects of type of therapy on implicit references to transference components and these replicated the findings from one-way ANOVAs reported above (see page 114). Further two-way ANOVAs also showed significant effects of type of therapy on the mean total number of different individual transference components explicitly and

explicitly and implicitly referred to in patient statements and again these effects replicated findings reported above (see pages 129-132).

Paired samples t-Test showed no significant effects of session order within the Cognitive-behaviour or within the Psychodynamic grouping of therapies.

The Six Therapy groups

A series of two-way repeated measures ANOVAs with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the six therapy groups with respect to the percentage of therapist statements in which each transference component was implicitly referred to, and the mean number per statement and rate of such references. These analyses did not show any significant effect of session order or of the interaction of session order and type of therapy. They did show a significant effect of type of therapy on implicit therapist references which replicated findings from one-way ANOVAs reported above (see pages 114-116). Two-way ANOVAs also showed significant effects of type of therapy on the mean total number of different individual transference components explicitly and explicitly and implicitly referred to in patient statements and these effects replicated findings reported above (see pages 129-132).

Table 5.69. Percentage of therapist statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which each transference component was implicitly identified (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	6.77	5.26	8.45	9.01
	(7.05)	(7.86)	(5.50)	(5.71)
Parent	0.24	1.41	2.10	3.96
	(0.63)	(2.84)	(2.53)	(4.01)
Current feeling	3.17	3.37	2.65	4.05
	(3.02)	(2.99)	(3.11)	(5.55)
Past feeling	0.78	1.44	6.06	5.13
	(0.95)	(2.64)	(4.23)	(6.21)
Conflict	2.43	2.84	11.16	9.20
	(2.42)	(5.25)	(8.12)	(5.58)

Table 5.70. Percentage of therapist statements across early and late sessions in which each of the 10 transference components were implicitly identified (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.	Conversational		Psychoanalytic	
Referent						
Therapist (E)	0.00	9.26	8.73	12.76	4.50	5.55
	(0.00)	(9.36)	(0.99)	(2.37)	(3.91)	(7.85)
Therapist (L)	0.00	6.52	7.63	13.54	7.85	0.00
	(0.00)	(5.68)	(2.72)	(8.65)	(5.19)	(0.00)
Parent (E)	0.00	0.00	0.73	2.16	3.08	0.00
	(0.00)	(0.00)	(0.99)	(2.52)	(2.96)	(0.00)
Parent (L)	0.00	1.86	1.10	3.76	6.20	0.00
	(0.00)	(2.62)	(0.42)	(3.70)	(3.13)	(0.00)
Current feeling (E)	0.27	3.64	4.75	3.38	3.08	0.00
	(0.31)	(2.82)	(3.26)	(2.91)	(2.91)	(0.00)
Current feeling (L)	1.97	4.24	3.33	3.42	6.85	0.00
	(1.82)	(4.27)	(2.18)	(5.52)	(5.52)	(0.00)
Past feeling (E)	0.20	0.72	1.28	5.66	6.83	5.55
	(0.35)	(0.66)	(1.42)	(4.41)	(4.41)	(7.85)
Past feeling (L)	0.00	1.66	2.25	3.68	9.50	0.00
	(0.00)	(2.74)	(2.27)	(4.92)	(4.92)	(0.00)
Conflict (E)	0.70	2.14	4.08	10.10	12.53	11.10
	(0.17)	(2.24)	(2.82)	(7.08)	(7.08)	(15.70)
Conflict (L)	0.17	3.84	3.60	10.20	8.98	7.15
	(0.29)	(6.71)	(0.47)	(4.05)	(4.05)	(10.11)

Table 5.71. The mean number of implicit references in a therapist statement to each transference component across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.071	0.055	0.086	0.096
	(0.076)	(0.055)	(0.057)	(0.100)
Parent	0.002	0.011	0.021	0.047
	(0.006)	(0.018)	(0.025)	(0.055)
Current feeling	0.038	0.055	0.027	0.051
	(0.037)	(0.100)	(0.031)	(0.065)
Past feeling	0.008	0.014	0.061	0.052
	(0.010)	(0.022)	(0.042)	(0.051)
Conflict	0.025	0.029	0.117	0.094
	(0.025)	(0.044)	(0.087)	(0.047)

Table 5.72. The mean number of implicit references in a therapist statement to each transference component across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Referent					
Therapist (E)	0.000	0.010	0.089	0.131	0.045	0.055
	(0.000)	(0.103)	(0.014)	(0.027)	(0.039)	(0.078)
Therapist (L)	0.000	0.070	0.079	0.145	0.083	0.000
	(0.000)	(0.066)	(0.032)	(0.122)	(0.057)	(0.000)
Parent (E)	0.000	0.000	0.007	0.022	0.031	0.000
	(0.000)	(0.000)	(0.010)	(0.025)	(0.030)	(0.000)
Parent (L)	0.000	0.019	0.010	0.054	0.062	0.000
	(0.000)	(0.026)	(0.004)	(0.074)	(0.032)	(0.000)
Current feeling (E)	0.003	0.052	0.048	0.034	0.031	0.000
	(0.003)	(0.041)	(0.033)	(0.037)	(0.029)	(0.000)
Current feeling (L)	0.020	0.093	0.033	0.041	0.090	0.000
	(0.019)	(0.155)	(0.022)	(0.039)	(0.090)	(0.000)
Past feeling (E)	0.002	0.007	0.013	0.057	0.069	0.055
	(0.003)	(0.007)	(0.014)	(0.037)	(0.045)	(0.078)
Past feeling (L)	0.000	0.017	0.023	0.037	0.096	0.000
	(0.000)	(0.027)	(0.023)	(0.031)	(0.051)	(0.000)
Conflict (E)	0.007	0.022	0.042	0.103	0.133	0.110
	(0.002)	(0.023)	(0.029)	(0.033)	(0.075)	(0.156)
Conflict (L)	0.002	0.039	0.036	0.116	0.094	0.070
	(0.003)	(0.068)	(0.005)	(0.158)	(0.046)	(0.100)

Table 5.73. The rate of therapist implicit references to individual transference components across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referent	Early	Late	Early	Late
Therapist	0.022	0.016	0.044	0.037
	(0.025)	(0.013)	(0.033)	(0.030)
Parent	0.001	0.005	0.009	0.020
	(0.002)	(0.010)	(0.011)	(0.022)
Current feeling	0.012	0.014	0.012	0.021
	(0.010)	(0.014)	(0.014)	(0.027)
Past feeling	0.002	0.005	0.032	0.024
	(0.003)	(0.010)	(0.029)	(0.025)
Conflict	0.008	0.007	0.067	0.044
	(0.007)	(0.008)	(0.062)	(0.026)

Table 5.74. The rate of therapist implicit references to individual transference components across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
		Cog.-beh.		Conversational		Psychoanalytic
Referent						
Therapist (E)	0.000	0.032	0.026	0.059	0.023	0.050
	(0.000)	(0.035)	(0.004)	(0.023)	(0.017)	(0.070)
Therapist (L)	0.000	0.019	0.025	0.051	0.037	0.000
	(0.000)	(0.012)	(0.008)	(0.032)	(0.022)	(0.000)
Parent (E)	0.000	0.000	0.002	0.009	0.015	0.000
	(0.000)	(0.000)	(0.003)	(0.009)	(0.013)	(0.000)
Parent (L)	0.000	0.008	0.004	0.020	0.031	0.000
	(0.000)	(0.015)	(0.002)	(0.027)	(0.016)	(0.000)
Current feeling (E)	0.002	0.016	0.014	0.015	0.016	0.000
	(0.002)	(0.011)	(0.009)	(0.014)	(0.016)	(0.000)
Current feeling (L)	0.013	0.018	0.011	0.014	0.040	0.000
	(0.013)	(0.019)	(0.008)	(0.012)	(0.038)	(0.000)
Past feeling (E)	0.002	0.002	0.003	0.023	0.035	0.050
	(0.003)	(0.002)	(0.003)	(0.016)	(0.020)	(0.070)
Past feeling (L)	0.000	0.008	0.007	0.015	0.047	0.000
	(0.000)	(0.015)	(0.006)	(0.012)	(0.024)	(0.000)
Conflict (E)	0.005	0.008	0.012	0.046	0.078	0.099
	(0.001)	(0.008)	(0.007)	(0.036)	(0.054)	(0.140)
Conflict (L)	0.001	0.008	0.012	0.041	0.044	0.049
	(0.002)	(0.009)	(0.005)	(0.016)	(0.016)	(0.069)

Further two-way ANOVAs showed a significant effect of the interaction of session order and type of therapy on the mean number of different types of transference components implicitly referred to per therapist statement and per line of therapist narrative ($F(5, 17) = 3.082$, $p<0.05$ and $F(5, 17) = 3.478$, $p<0.05$). Further analysis of these interactions showed just one significant difference, that between the Cognitive-behaviour and Psychoanalytic therapy groups in the mean number of different components implicitly referred to in therapist statements ($F(5, 17) = 10.655$, $p<0.05$). These were higher in both early and late sessions of the Cognitive-behaviour group than in the Psychoanalytic therapy group. But whereas the number of references increased in late over early sessions of Cognitive-behaviour therapy they decreased in Psychoanalytic psychotherapy.

There were no other significant effects of session order, type of therapy or the interaction of session order and type of therapy on therapist explicit and therapist implicit references to transference components.

Summary

Therapists references to transference components across early and late sessions

Some support was obtained for the hypothesis that explicit references to the therapist would increase in late over early sessions of the Psychodynamic psychotherapy group.

Support was not obtained for the hypothesis that explicit references to the therapist would be higher in early sessions of the Psychodynamic psychotherapy group than of the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was obtained for the hypothesis that explicit references to the therapist would be higher in late sessions of the Psychodynamic psychotherapy group than of the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was obtained for the hypothesis that explicit references to the therapist would not be significantly more or less in late over early sessions of the Psychoanalytic psychotherapy group.

Support was obtained for the hypotheses that explicit references to the therapist would be higher in early and late sessions of the Psychoanalytic psychotherapy group than of the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

There was some evidence that explicit references to the therapist tended to increase in late sessions over early of Behaviour, Cognitive-behaviour and Conversational therapies.

Support was obtained for the hypothesis that explicit references to parents would increase in late over early sessions of Psychoanalytic psychotherapy.

Support was not obtained for the hypothesis that, with the exception of in the Psychoanalytic group, there would be no difference across early and late sessions of therapy in the level of explicit references to parents. In fact there was some evidence of references increasing in the Cognitive-behaviour and Cognitive groups and decreasing in the Behaviour and Conversational groups.

Partial support was obtained for the hypothesis that the total number of different transference components implicitly referred to in therapists' statements would increase in late over early

sessions of the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In fact there was support for their increasing in the Cognitive-behaviour group.

Partial support was obtained for the hypothesis that the total number of different transference components implicitly referred to in therapists' statements would decrease in late over early sessions of the Psychodynamic and Psychoanalytic psychotherapy groups. In fact there was support for their decreasing in the Psychoanalytic group.

Partial support was obtained for the hypothesis that the total number of different transference components implicitly referred to in therapists' statements would be higher in late sessions of the Behaviour, Cognitive-behaviour and Cognitive therapy groups than in late sessions of the Psychodynamic and Psychoanalytic psychotherapy groups. In fact there was support for their being higher in late sessions of the Cognitive-behaviour group than in late sessions of the Psychoanalytic group.

5.4.2 Linking of Transference Components within Statements

Patient and therapist statements were analysed across the two therapy groupings Cognitive-behaviour (Behaviour, Cognitive-behaviour and Cognitive) and Psychodynamic (Conversational, Psychodynamic and Psychoanalytic) and across early and late sessions, and across the six therapy groups and across early and late sessions to ascertain which transference components were linked together within statements and how frequently.

i) Patient Linking of Explicit References to Transference Components within Statements

The percentage of patient statements within sessions in which explicit references to transference components were linked together was analysed. Mean percentages of each of these linked references are presented for the two therapy groupings, Cognitive-behaviour and Psychodynamic, in Table 5.75 and for each of the six therapy groups in Tables 5.76a (for the linking of two components) and 5.76b (for the linking of three or more components).

This section of analyses includes testing of the hypothesis that patients' linking of explicit references to the therapist and current feeling and to the therapist, current feeling and conflict will increase in late over early sessions of the Psychodynamic grouping of therapies and decrease in the Cognitive-behaviour grouping of therapies

The Two Therapy Groupings

A two-way repeated measures ANOVA with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of patient statements in each in which the various transference components were linked together by explicit references. The analysis showed there was a significant increase in late sessions over early of the percentage of statements linking explicit references to therapist, current feeling and conflict ($F(1, 21) = 6.186$, $p<0.05$). This linking also showed a significant interaction with type of therapy ($F(1, 21) = 5.523$, $p<0.05$) with the Psychodynamic grouping containing a higher percentage of statements in both early and late sessions containing such links and a larger increase in them in late sessions over early than in the Cognitive-behaviour group. A paired samples t-Test also showed late sessions of the Psychodynamic grouping of therapies to have a significantly higher percentage of statements linking explicit references to the therapist, current feelings and conflict than did early sessions ($t(10) = 2.351$, $p<0.05$).

The Six Therapy Groups

A two-way repeated measures ANOVA, with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared patient linking of explicit references to transference components across the six therapy groups. This showed there was a significant increase in late sessions over early of the percentage of statements linking explicit references to therapist, current feeling and conflict ($F(1, 17) = 11.487$, $p<0.005$) and an interaction of this with type of therapy ($F(5, 17) = 3.184$, $p<0.05$). There was also a significant interaction between session order and type of therapy on references to the therapist, parent and current feeling ($F(5, 17) = 4.761$, $p<0.01$). However further analysis of these interactions did not show significant differences between any two groups.

Table 5.75. Mean Percentage of patient statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which explicit transference referents are linked (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referents Linked	Early	Late	Early	Late
Parent and past feeling	1.11	0.61	5.49	7.33
	(1.54)	(1.12)	(8.15)	(12.91)
Therapist and current feeling	4.25	4.02	28.17	24.29
	(3.58)	(3.42)	(23.01)	(12.19)
Current feeling and conflict	7.17	5.43	23.44	22.72
	(7.34)	(4.98)	(19.89)	(9.35)
Parent and Conflict	1.36	0.93	7.15	10.81
	(1.77)	(1.47)	(9.28)	(14.45)
Current and past feeling	1.09	0.97	6.14	8.16
	(1.97)	(1.60)	(7.31)	(12.71)
Therapist, current feeling and conflict	0.51	0.68	6.02	12.19
	(1.19)	(0.99)	(7.55)	(9.96)
Parent, past feeling and conflict	0.52	0.14	2.36	3.43
	(1.13)	(0.49)	(3.45)	(4.83)
Therapist, current and past feeling	0.00	0.00	2.93	1.54
	(0.00)	(0.00)	(6.51)	(4.30)
Parent, current and past feeling	0.59	0.61	4.21	6.86
	(1.05)	(1.12)	(5.63)	(12.68)
Therapist, parent and past feeling	0.00	0.00	1.72	1.54
	(0.00)	(0.00)	(3.59)	(4.30)
Therapist, parent and current feeling	0.00	0.00	2.47	4.61
	(0.00)	(0.00)	(3.43)	(7.97)
Therapist, parent, current and past feeling	0.00	0.00	1.45	1.54
	(0.00)	(0.00)	(3.35)	(4.30)
Therapist, parent, past feelings and conflict	0.00	0.00	0.17	1.54
	(0.00)	(0.00)	(0.57)	(4.30)
Therapist, parent, current and past feeling and conflict	0.00	0.00	0.17	1.54
	(0.00)	(0.00)	(0.57)	(4.30)

Table 5.76a. Mean Percentage of patient statements across early and late sessions in which two explicit transference referents are linked (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Psychodynamic Conversational		Psychoanalytic
Referents Linked						
Parent and past feeling						
early	1.23	1.00	1.18	1.88	7.20	11.10
	(1.97)	(1.65)	(1.56)	(2.32)	(9.24)	(15.70)
late	0.00	0.66	1.00	1.64	7.38	21.45
	(0.00)	(1.09)	(1.57)	(1.92)	(7.57)	(30.33)
Therapist and current feeling						
early	1.23	3.72	7.18	16.18	23.90	66.70
	(1.37)	(1.75)	(4.56)	(15.02)	(14.52)	(15.69)
late	0.87	5.22	4.88	17.40	31.65	26.80
	(1.50)	(1.91)	(4.82)	(10.05)	(14.25)	(2.55)
Current feeling and conflict						
early	4.50	9.82	5.85	13.90	19.30	55.55
	(3.90)	(10.71)	(3.62)	(4.85)	(9.77)	(31.47)
late	0.60	9.30	4.20	20.10	23.95	26.80
	(0.66)	(5.31)	(1.70)	(7.98)	(13.41)	(2.55)
Parent and Conflict						
early	1.16	1.96	0.75	2.52	5.43	22.20
	(2.02)	(2.26)	(0.87)	(2.36)	(2.66)	(15.70)
late	0.30	1.44	0.78	4.22	8.38	32.15
	(0.52)	(2.11)	(0.97)	(4.33)	(8.67)	(25.24)
Current and past feeling						
early	2.33	0.24	1.30	3.64	7.53	11.10
	(2.23)	(0.54)	(1.45)	(2.94)	(7.43)	(15.70)
late	0.17	0.86	1.70	3.52	7.33	21.45
	(0.29)	(1.02)	(2.55)	(3.29)	(7.91)	(30.33)

A two-way repeated measures ANOVA also showed a significant decrease in late over early sessions of patients' linking of explicit references to therapist and current feeling ($F(1, 17) = 5.134$, $p<0.05$) with this showing a significant interaction with type of therapy ($F(5, 17) = 5.829$, $p<0.005$). Further analysis of this interaction showed significant differences between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group with respect to the effects of session order ($F(1, 3) = 324.161$, $p< 0.001$) and the interaction of session order and therapy ($F(1, 3) = 312.161$, $p<0.001$). The Psychoanalytic psychotherapy group had higher percentage of statements linking references to the therapist and current feeling than the Behaviour therapy group in both early and late sessions with the references decreasing in late over early sessions of both therapy groups.

Table 5.76b. Mean Percentage of patient statements across early and late sessions in which three or more explicit transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Therapist, current feeling and conflict						
early	0.07	0.00	1.48	3.78	6.28	11.10
	(0.12)	(0.00)	(1.81)	(2.38)	(8.63)	(15.70)
late	0.00	1.22	0.53	5.94	12.70	26.80
	(0.00)	(1.30)	(0.61)	(5.95)	(8.58)	(2.55)
Parent, past feeling and conflict						
early	0.40	1.00	0.00	1.64	1.68	5.55
	(0.69)	(1.65)	(0.00)	(2.31)	(1.68)	(7.85)
late	0.00	0.34	0.00	1.64	3.80	7.15
	(0.00)	(0.76)	(0.00)	(1.92)	(4.91)	(10.11)
Therapist, current and past feeling						
early	0.00	0.00	0.00	0.94	1.33	5.55
	(0.00)	(0.00)	(0.00)	(1.33)	(1.54)	(7.85)
late	0.00	0.00	0.00	0.00	0.65	7.15
	(0.00)	(0.00)	(0.00)	(0.00)	(1.30)	(10.11)
Parent, current and past feeling						
early	1.23	0.24	0.55	1.88	6.45	22.20
	(1.97)	(0.54)	(0.68)	(2.31)	(7.80)	(10.97)
late	0.00	0.66	0.00	1.64	6.10	21.45
	(0.00)	(1.09)	(0.00)	(1.92)	(6.05)	(30.33)
Therapist, parent and past feeling						
early	0.00	0.00	0.00	0.38	1.48	6.13
	(0.00)	(0.00)	(0.00)	(0.85)	(2.95)	(7.84)
late	0.00	0.00	0.00	0.00	0.65	7.15
	(0.00)	(0.00)	(0.00)	(0.00)	(1.30)	(10.11)
Therapist, parent and current feeling						
early	0.00	0.00	0.00	1.42	2.25	5.55
	(0.00)	(0.00)	(0.00)	(2.43)	(1.62)	(7.85)
late	0.00	0.00	0.00	0.88	1.75	19.65
	(0.00)	(0.00)	(0.00)	(1.26)	(2.41)	(7.57)
Therapist, parent, current and past feeling						
early	0.00	0.00	0.00	0.38	0.73	5.55
	(0.00)	(0.00)	(0.00)	(0.85)	(1.45)	(7.85)
late	0.00	0.00	0.00	0.00	0.65	7.15
	(0.00)	(0.00)	(0.00)	(0.00)	(1.30)	(10.01)
Therapist, parent, past feeling and conflict						
early	0.00	0.00	0.00	0.38	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.85)	(0.00)	(0.00)
late	0.00	0.00	0.00	0.00	0.65	7.15
	(0.00)	(0.00)	(0.00)	(0.00)	(1.30)	(11.01)
Therapist, parent, current and past feeling and conflict						
early	0.00	0.00	0.00	0.38	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.85)	(0.00)	(0.00)
late	0.00	0.00	0.00	0.00	0.65	7.15
	(0.00)	(0.00)	(0.00)	(0.00)	(1.30)	(6.19)

ii) the Cognitive-behaviour therapy group with respect to the effects of session order ($F(1, 5) = 205.634$, $p < 0.001$) and the interaction of session order and therapy type ($F(1, 5) = 239.019$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist and current feeling than the Cognitive-behaviour therapy group in both early and late sessions with the references increasing in late over early sessions of the Cognitive-behaviour therapy group and decreasing in the Psychoanalytic.

iii) the Cognitive therapy group with respect to the effects of session order ($F(1, 4) = 42.254$, $p<0.005$) and the interaction of session order and therapy type ($F(1, 4) = 33.544$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist and current feeling than the Cognitive therapy group in both early and late sessions with the references decreasing in late over early sessions of both therapy groups.

iv) the Conversational therapy group with respect to the effects of session order ($F(1, 5) = 28.872$, $p<0.005$) and the interaction of session order and therapy type ($F(1, 5) = 32.629$, $p<0.005$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist and current feeling than the Conversational therapy group in both early and late sessions with the references decreasing in late over early sessions of the Psychoanalytic group and increasing in the Conversational.

ii) Patient Linking of Explicit and Implicit References to Transference Components within Statements

The percentage of patient statements within sessions in which transference components were linked together by either explicit or implicit references to them was analysed. Mean percentages of each of these linked references are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table 5.77 and for each of the six therapy groups in Table 5.78a (for the linking of two components) and Table 5.78b (for the linking of three or more components).

The Two Therapy Groupings and The Six Therapy Groups

A two-way repeated measures ANOVA with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies, and the six therapy groups, with respect to the percentage of patient statements in each in which the various transference components were linked together by explicit and implicit references. These two sets of analyses showed no significant effect either of session order or of the interaction of session order and therapy. However a paired

Table 5.77. Mean Percentage of patient statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which explicit and implicit transference referents are linked (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referents Linked	Early	Late	Early	Late
Parent and past feeling	3.53	2.39	14.42	17.01
	(3.18)	(2.57)	(11.29)	(15.76)
Therapist and current feeling	20.14	20.41	47.33	47.36
	(10.68)	(10.83)	(21.65)	(14.69)
Current feeling and conflict	14.47	13.89	37.36	35.80
	(7.89)	(7.11)	(22.43)	(12.48)
Parent and Conflict	2.55	2.21	16.63	18.67
	(2.51)	(2.63)	(19.37)	(16.75)
Current and past feeling	5.35	3.63	18.09	19.66
	(4.37)	(3.74)	(9.01)	(16.75)
Therapist, current feeling and conflict	9.46	9.43	29.64	30.22
	(5.76)	(7.33)	(24.24)	(13.47)
Parent, past feeling and conflict	1.76	1.43	10.85	11.41
	(1.99)	(1.86)	(10.22)	(11.16)
Therapist, current and past feeling	3.08	1.61	12.49	13.66
	(3.04)	(2.48)	(9.28)	(12.50)
Parent, current and past feeling	2.74	2.40	13.04	16.55
	(2.63)	(2.57)	(1.55)	(15.47)
Therapist, parent and past feeling	1.80	0.86	10.87	11.41
	(1.77)	(1.62)	(10.61)	(10.48)
Therapist, parent and current feeling	1.78	1.13	14.41	15.43
	(1.82)	(1.57)	(18.13)	(10.84)
Therapist, parent, current and past feeling	1.62	0.86	9.60	11.41
	(1.74)	(1.62)	(9.57)	(10.48)
Therapist, parent, past feelings and conflict	0.88	0.48	8.71	8.93
	(0.98)	(0.81)	(10.33)	(9.93)
Therapist, parent, current and past feeling and conflict	0.70	0.48	7.70	8.93
	(0.79)	(0.81)	(9.37)	(9.93)

samples t-Test showed that early sessions of the Cognitive-behaviour grouping of therapies contained significantly higher percentages of statements in which the therapist, parents and past feelings were linked together by explicit and implicit references than did early sessions ($t(11) = 3.409$, $p<0.01$).

Significant effects of type of therapy were obtained across the two therapy groupings and the six therapy groups on patients' linking of various explicit references and various explicit and implicit references, and these replicated findings from one-way ANOVAs reported above (see pages 138-148).

Table 5.78a. Mean Percentage of patient statements across early and late sessions in which two transference referents are linked (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Parent and past feeling						
early	1.63	4.30	4.00	8.90	14.65	11.10
	(2.66)	(3.14)	(3.78)	(5.31)	(14.05)	(7.84)
late	0.00	4.40	1.68	11.80	21.30	21.45
	(0.00)	(2.64)	(1.37)	(10.40)	(17.15)	(30.33)
Therapist and current feeling						
early	6.23	23.20	26.75	37.16	42.03	66.45
	(1.97)	(9.58)	(5.10)	(11.60)	(11.08)	(23.45)
late	10.00	26.18	21.00	45.06	50.70	46.45
	(6.89)	(11.75)	(7.07)	(15.27)	(19.38)	(5.03)
Current feeling and conflict						
early	11.27	15.10	16.08	27.86	34.60	55.55
	(2.85)	(10.30)	(8.17)	(9.62)	(8.95)	(47.16)
late	8.07	18.08	13.03	31.18	42.50	26.80
	(3.89)	(9.10)	(0.82)	(9.11)	(16.04)	(21.66)
Parent and Conflict						
early	1.67	3.16	2.53	6.62	12.45	22.20
	(2.71)	(2.84)	(2.41)	(5.26)	(9.78)	(11.65)
late	0.30	3.68	1.80	10.62	18.43	32.15
	(0.52)	(3.29)	(1.80)	(8.31)	(13.93)	(7.85)
Current and past feeling						
early	3.20	6.54	5.48	14.52	17.73	11.10
	(5.37)	(4.44)	(4.19)	(6.70)	(10.34)	(7.84)
late	0.17	6.18	3.03	16.68	22.50	21.45
	(0.29)	(3.72)	(3.08)	(15.07)	(17.26)	(30.33)

Table 5.78b. Mean Percentage of patient statements across early and late sessions in which three or more transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.	Conversational		Psychoanalytic	
Referents Linked						
Therapist, current feeling and conflict						
early	4.47	10.50	11.90	20.34	22.75	30.29
	(1.89)	(6.77)	(4.83)	(6.59)	(6.18)	(23.56)
late	6.17	12.48	8.05	20.60	35.38	26.80
	(6.25)	(10.25)	(1.54)	(8.60)	(18.86)	(12.65)
Parent, past feeling and conflict						
early	0.60	2.42	1.80	5.68	8.85	5.55
	(1.04)	(2.28)	(2.17)	(3.98)	(8.13)	(7.85)
late	0.00	2.60	1.03	8.28	13.88	7.15
	(0.00)	(2.32)	(0.97)	(9.36)	(11.50)	(9.13)
Therapist, current and past feeling						
early	0.00	4.88	3.15	7.82	10.70	27.75
	(0.00)	(3.48)	(1.71)	(4.35)	(6.76)	(7.85)
late	0.00	2.86	1.25	12.14	15.25	14.30
	(0.00)	(3.39)	(1.37)	(11.49)	(14.18)	(20.22)
Parent, current and past feeling						
early	1.63	3.54	2.58	8.66	13.93	22.20
	(2.66)	(3.55)	(1.81)	(5.49)	(12.63)	(15.70)
late	0.00	4.40	1.70	11.80	20.03	21.45
	(0.00)	(2.64)	(1.38)	(10.40)	(16.65)	(30.33)
Therapist, parent and past feeling						
early	0.00	3.00	1.65	5.48	9.18	6.13
	(0.00)	(1.80)	(1.24)	(3.67)	(9.74)	(2.37)
late	0.00	1.82	0.30	8.70	13.35	7.15
	(0.00)	(2.25)	(0.36)	(6.62)	(12.18)	(8.19)
Therapist, parent and current feeling						
early	0.00	2.98	1.60	7.28	11.08	38.90
	(0.00)	(1.98)	(1.16)	(5.17)	(6.72)	(39.90)
late	0.17	2.38	0.30	10.16	16.33	26.80
	(0.29)	(1.81)	(0.36)	(5.85)	(14.51)	(2.55)
Therapist, parent, current and past feeling						
early	0.00	2.74	1.43	5.48	8.45	22.20
	(0.00)	(1.96)	(1.11)	(3.67)	(8.33)	(15.70)
late	0.00	1.82	0.30	8.70	13.35	14.30
	(0.00)	(2.25)	(0.36)	(6.62)	(12.18)	(20.22)
Therapist, parent, past feeling and conflict						
early	0.00	1.46	0.80	4.00	5.08	27.75
	(0.00)	(0.99)	(0.92)	(3.28)	(4.92)	(7.85)
late	0.00	1.00	0.18	5.98	9.93	14.30
	(0.00)	(1.05)	(0.35)	(6.32)	(10.20)	(20.22)
Therapist, parent, current and past feeling and conflict						
early	0.00	1.20	0.60	4.00	5.08	22.20
	(0.00)	(0.76)	(0.77)	(3.28)	(4.92)	(15.70)
late	0.00	1.00	0.18	5.98	9.93	14.30
	(0.00)	(1.06)	(0.35)	(6.32)	(10.20)	(20.22)

Summary

Linking of transference components in patient statements across early and late sessions

Support was obtained for the hypothesis that patient linking of explicit references to the therapist, current feeling and conflict would increase in late sessions over early of the Psychodynamic grouping of therapies.

Support was not obtained for the hypothesis that patient linking of explicit references to the therapist, current feeling and conflict would decrease in late sessions over early of the Cognitive-behaviour grouping of therapies. In fact there was a small non significant increase in such linking.

Support was not obtained for the hypothesis that patient linking of explicit references to the therapist and current feeling would increase in late sessions over early of the Psychodynamic grouping of therapies and decrease in late sessions over early of the Cognitive-behaviour grouping of therapies.

Patient linking of explicit references to the therapist and current feeling increased in late over early sessions of the Cognitive-behaviour and decreased in the Behaviour, Cognitive, Conversational and Psychoanalytic therapy groups. The Psychoanalytic group had the highest occurrence of such linking in early sessions and the Psychodynamic group the highest in late sessions.

Patient linking of explicit and implicit references to the therapist, parent and past feeling decreased in late over early sessions of the Cognitive-behaviour grouping of therapies.

iii) Therapist Linking of Explicit References to Transference Components within Statements

The percentage of therapist statements within sessions in which explicit references to transference components were linked together was analysed. Mean percentages of each of these linked references are presented for the two therapy groupings, Cognitive-behaviour and Psychodynamic, in Table 5.79 and for each of the six therapy groups in Table 5.80a (for the linking of two components) and Table 80b (for the linking of three or more components).

This section of analyses includes testing of the hypothesis that therapists' linking of explicit references to the therapist and current feeling and to the therapist, current feeling and conflict will increase in late over early sessions of the Psychodynamic grouping of therapies and decrease in the Cognitive-behaviour grouping of therapies.

Table 5.79. Mean Percentage of therapist statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which explicit transference referents are linked (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referents Linked	Early	Late	Early	Late
Parent and past feeling	0.28 (0.95)	0.09 (0.32)	3.15 (4.56)	2.72 (4.57)
Therapist and current feeling	2.13 (2.34)	2.01 (3.09)	15.28 (12.68)	22.21 (10.43)
Current feeling and conflict	3.16 (4.09)	1.77 (2.80)	9.56 (8.63)	13.59 (10.09)
Parent and Conflict	0.07 (0.23)	0.59 (1.28)	1.29 (1.88)	2.83 (3.90)
Current and past feeling	0.28 (0.95)	0.00 (0.00)	3.70 (4.25)	2.10 (2.48)
Therapist, current feeling and conflict	0.45 (0.79)	0.04 (0.14)	1.93 (3.18)	9.99 (10.49)
Parent, past feeling and conflict	0.00 (0.00)	0.00 (0.00)	1.03 (1.83)	1.45 (2.50)
Therapist, current and past feeling	0.00 (0.00)	0.00 (0.00)	0.42 (0.73)	0.84 (1.64)
Parent, current and past feeling	0.13 (0.46)	0.00 (0.00)	2.16 (3.47)	1.58 (2.41)
Therapist, parent and past feeling	0.00 (0.00)	0.00 (0.00)	0.31 (0.69)	0.84 (1.64)
Therapist, parent and current feeling	0.00 (0.00)	0.00 (0.00)	3.73 (9.89)	2.40 (4.47)
Therapist, parent, current and past feeling	0.00 (0.00)	0.00 (0.00)	0.31 (0.69)	0.84 (1.64)
Therapist, parent, past feelings and conflict	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.84 (1.64)
Therapist, parent, current and past feeling and conflict	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.84 (1.64)

The Two Therapy Groupings

A two-way repeated measures ANOVA with one within-subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements in each in which the various transference components were linked together by explicit references. The analysis showed there was a significant increase in late sessions over early of the percentage of statements linking explicit references to therapist, current feeling and conflict ($F(1, 21) = 8.843$, $p<0.01$). This showed a significant interaction with type of therapy ($F(1, 21) = 5.523$, $p<0.05$) with the Psychodynamic grouping containing a higher percentage of statements in both early and late sessions containing such links and with it also showing an increase of the linking in late sessions whereas the Cognitive-behaviour grouping showed a decrease.

Table 5.80a. Mean Percentage of therapist statements across early and late sessions in which two explicit transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
Referents Linked		Cog.-beh.		Conversational		Psychoanalytic
Parent and past feeling						
early	0.00	0.00	0.83	2.30	5.80	0.00
	(0.00)	(0.00)	(1.65)	(3.09)	(6.27)	(0.00)
late	0.00	0.00	0.28	0.34	7.05	0.00
	(0.00)	(0.00)	(0.55)	(0.76)	(5.43)	(0.00)
Therapist and current feeling						
early	0.20	1.72	4.08	11.90	10.50	33.30
	(0.35)	(0.69)	(3.22)	(11.63)	(9.45)	(22.43)
late	0.17	2.02	3.38	15.64	28.13	26.80
	(0.29)	(1.55)	(5.08)	(9.04)	(10.89)	(25.46)
Current feeling and conflict						
early	0.07	4.72	3.53	7.34	8.80	16.65
	(0.12)	(5.46)	(2.82)	(2.71)	(3.41)	(23.55)
late	0.17	2.62	1.90	8.00	13.98	26.80
	(0.29)	(4.10)	(1.57)	(8.80)	(8.09)	(19.87)
Parent and Conflict						
early	0.00	0.00	0.20	1.20	2.05	0.00
	(0.00)	(0.00)	(0.40)	(1.25)	(2.79)	(0.00)
late	0.00	0.16	1.58	1.34	6.10	0.00
	(0.00)	(0.36)	(1.58)	(2.21)	(4.57)	(0.00)
Current and past feeling						
early	0.00	0.00	0.83	2.72	4.00	5.55
	(0.00)	(0.00)	(1.65)	(2.40)	(5.30)	(7.85)
late	0.00	0.00	0.00	1.48	3.93	0.00
	(0.00)	(0.00)	(0.00)	(2.04)	(2.64)	(0.00)

Table 5.80b. Mean Percentage of therapist statements across early and late sessions in which three or more explicit transference referents are linked (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Therapist, current feeling and conflict						
early	0.00	0.36	0.90	1.08	1.18	5.55
	(0.00)	(0.54)	(1.19)	(0.70)	(1.36)	(7.85)
late	0.00	0.00	0.13	2.38	11.10	26.80
	(0.00)	(0.00)	(0.25)	(2.78)	(8.22)	(13.98)
Parent, past feeling and conflict						
early	0.00	0.00	0.00	0.62	2.05	0.00
	(0.00)	(0.00)	(0.00)	(0.88)	(2.79)	(0.00)
late	0.00	0.00	0.00	0.34	3.58	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(3.26)	(0.00)
Therapist, current and past feeling						
early	0.00	0.00	0.00	0.54	0.48	0.00
	(0.00)	(0.00)	(0.00)	(0.75)	(0.95)	(0.00)
late	0.00	0.00	0.00	0.34	1.88	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(2.43)	(0.00)
Parent, current and past feeling						
early	0.00	0.00	0.40	1.56	4.00	0.00
	(0.00)	(0.00)	(0.80)	(1.69)	(5.30)	(0.00)
late	0.00	0.00	0.00	0.34	3.93	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(2.64)	(0.00)
Therapist, parent and past feeling						
early	0.00	0.00	0.00	0.30	0.48	0.00
	(0.00)	(0.00)	(0.00)	(0.67)	(0.95)	(0.00)
late	0.00	0.00	0.00	0.34	1.88	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(2.43)	(0.00)
Therapist, parent and current feeling						
early	0.00	0.00	0.00	0.30	1.55	16.65
	(0.00)	(0.00)	(0.00)	(0.67)	(1.88)	(23.55)
late	0.00	0.00	0.00	0.34	6.18	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(5.98)	(0.00)
Therapist, parent, current and past feeling						
early	0.00	0.00	0.00	0.30	0.48	0.00
	(0.00)	(0.00)	(0.00)	(0.67)	(0.95)	(0.00)
late	0.00	0.00	0.00	0.34	1.88	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(2.43)	(0.00)
Therapist, parent, past feeling and conflict						
early	0.00	0.00	0.00	0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
late	0.00	0.00	0.00	0.34	1.88	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(2.43)	(0.00)
Therapist, parent, current and past feeling and conflict						
early	0.00	0.00	0.00	0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
late	0.00	0.00	0.00	0.34	1.88	0.00
	(0.00)	(0.00)	(0.00)	(0.76)	(2.43)	(0.00)

Paired samples t-Tests showed therapist linking of explicit references to the therapist, current feeling and conflict increased in late over early sessions of the Psychodynamic grouping ($t(10) = 3.002$, $p<0.01$) and decreased in the Cognitive-behaviour grouping ($t(11) = 2.096$, $p<0.05$).They also showed linking of references to the therapist and current feeling increased in late over early sessions of the Psychodynamic grouping ($t(10) = 1.931$, $p<0.05$).

The Six Therapy Groups

A two-way repeated measures ANOVA, with one within-subject factor (session order) and one between-subjects factor (type of therapy), compared therapist linking of explicit references to transference components across the six therapy groups. This showed a significant increase in late sessions over early sessions of the percentage of statements linking explicit references to parent and conflict ($F(1, 17) = 4.734$, $p<0.05$), and therapist, current feeling and conflict ($F(1, 17) = 46.467$, $p<0.001$). There was a significant interaction between session order and type of therapy on therapists' linking of explicit references to therapist and current feeling ($F(5, 17) = 5.301$, $p<0.005$) and therapist, current feeling and conflict ($F(5, 17) = 16.455$, $p<0.001$).

Further analysis of therapists' linking of explicit references to the therapist and current feeling showed a significant difference between:

i) the Psychodynamic and the Cognitive-behaviour therapy groups with respect to the effects of session order ($F(1, 7) = 13.610$, $p< 0.01$) and the interaction of session order and therapy type group ($F(1, 7) = 12.714$, $p<0.01$). The Psychodynamic psychotherapy group had a higher percentage of statements linking references to the therapist and current feelings than the Cognitive-behaviour therapy group in both early and late sessions with the references increasing in late over early sessions of both groups.

ii) the Psychoanalytic and the Cognitive-behaviour therapy groups with respect to the effects of session order ($F(1, 5) = 14.906$, $p< 0.05$) and the interaction of session order and therapy type group ($F(1, 5) = 17.931$, $p<0.01$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist and current feelings than the Cognitive-behaviour therapy group in both early and late sessions with the references decreasing in late over early sessions of the Psychoanalytic group and increasing in the Cognitive-behaviour therapy group.

Further analysis of therapists' linking of explicit references to the therapist, current feeling and conflict showed significant differences between the Psychoanalytic psychotherapy group and:

i) the Behaviour therapy group in the effects of session order ($F(1, 3) = 57.80$, $p < 0.005$) and the interaction of session order and therapy type ($F(1, 3) = 57.80$, $p<0.005$). The Behaviour therapy group had no references in either early or late sessions and the Psychoanalytic psychotherapy group saw references increasing in late over early sessions.

ii) the Cognitive-behaviour therapy group in the effects of session order ($F(1, 5) = 106.469$, $p<0.005$) and the interaction of session order and therapy type ($F(1, 5) = 113.934$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist, current feeling and conflict than the Cognitive-behaviour therapy group in both early and late sessions with the references increasing in late over early sessions of the Psychoanalytic group and decreasing in the Cognitive-behaviour therapy group.

iii) the Cognitive therapy group in the effects of session order ($F(1, 4) = 72.282$ $p<0.001$) and the interaction of session order and therapy type ($F(1, 4) = 83.640$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist, current feeling and conflict than the Cognitive therapy group in both early and late sessions with the references increasing in late over early sessions of the Psychoanalytic group and decreasing in the Cognitive therapy group.

iv) the Conversational psychotherapy group in the effects of session order ($F(1, 5) = 67.910$, $p<0.001$) and the interaction of session order and therapy type ($F(1, 5) = 53.153$, $p<0.001$). The Psychoanalytic psychotherapy group had a higher percentage of statements linking references to the therapist, current feeling and conflict than the Conversational therapy group in both early and late sessions with the references increasing in late over early sessions of both groups.

iv) Therapist Linking of Explicit and Implicit References to Transference Components within Statements

The percentage of therapist statements within sessions in which various transference components were linked together by either explicit or implicit references to them was analysed. Mean percentages of each of these linked references are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table 5.81 and for each of the six therapy groups in Table 5.82a (for the linking of two components) and Table 5.82b (for the linking of three or more components).

Table 5.81. Mean Percentage of therapist statements across early and late sessions and by Cognitive-behaviour and Psychodynamic therapies in which explicit and implicit transference referents are linked (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Referents Linked	Early	Late	Early	Late
Parent and past feeling	0.34	0.95	6.36	7.32
	(1.18)	(1.73)	(6.78)	(8.24)
Therapist and current feeling	8.07	7.06	23.73	30.85
	(7.02)	(7.28)	(13.06)	(14.17)
Current feeling and conflict	5.49	4.43	18.71	22.18
	(5.77)	(6.50)	(11.57)	(11.99)
Parent and Conflict	0.13	1.08	4.28	6.02
	(0.46)	(1.65)	(5.26)	(5.86)
Current and past feeling	0.99	1.20	8.52	6.04
	(1.85)	(1.77)	(6.60)	(5.80)
Therapist, current feeling and conflict	2.40	1.88	8.94	15.97
	(2.75)	(3.37)	(8.09)	(10.60)
Parent, past feeling and conflict	0.07	0.10	3.26	3.55
	(0.23)	(0.24)	(3.67)	(4.81)
Therapist, current and past feeling	0.25	0.71	2.90	3.06
	(0.72)	(1.24)	(3.36)	(4.03)
Parent, current and past feeling	0.21	0.68	4.58	5.18
	(0.72)	(1.58)	(4.54)	(4.94)
Therapist, parent and past feeling	0.00	0.53	1.30	3.28
	(0.00)	(0.95)	(1.53)	(4.47)
Therapist, parent and current feeling	0.00	0.78	4.71	4.79
	(0.00)	(1.00)	(9.72)	(5.63)
Therapist, parent, current and past feeling	0.00	0.43	1.30	2.83
	(0.00)	(0.94)	(1.53)	(3.62)
Therapist, parent, past feelings and conflict	0.00	0.06	0.82	1.89
	(0.00)	(0.20)	(1.57)	(3.01)
Therapist, parent, current and past feeling and conflict	0.00	0.06	0.82	1.89
	(0.00)	(0.20)	(1.57)	(3.01)

The Two Therapy Groupings and the Six Therapy Groups

A two-way repeated measures ANOVA with one within subject factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies, and the six therapy groups with respect to the percentage of therapist statements in each in which the various transference components were linked together by explicit and implicit references. This analysis showed a significant interaction

between session order and type of therapy across the six groups on therapists' linking of explicit and implicit references to therapist and current feeling ($F(5, 17) = 4.929$, $p<0.01$). However further analysis of the interaction did not show a significant difference between any two of the six therapy groups.

Significant effects of type of therapy were obtained across the two therapy groupings and the six therapy groups on therapist' linking of various explicit references and various explicit and implicit references, and these replicated findings from one-way ANOVAs reported above (see pages 152-159).

Table 5.82a. Mean Percentage of therapist statements across early and late sessions in which two transference referents are linked (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Parent and past feeling						
early	0.00	0.00	1.03	5.72	10.35	0.00
	(0.00)	(0.00)	(2.05)	(4.34)	(8.90)	(0.00)
late	0.00	1.10	1.48	4.82	14.10	0.00
	(0.00)	(2.46)	(1.28)	(4.63)	(9.51)	(0.00)
Therapist and current feeling						
early	0.40	9.18	12.43	24.04	15.78	38.85
	(0.35)	(7.73)	(3.89)	(11.36)	(11.80)	(7.85)
late	0.17	8.16	10.85	28.02	36.43	26.80
	(0.29)	(7.16)	(7.56)	(14.24)	(18.19)	(2.55)
Current feeling and conflict						
early	0.77	6.86	7.33	16.80	19.35	22.20
	(0.29)	(7.09)	(4.98)	(7.79)	(4.73)	(31.40)
late	0.30	6.06	5.48	17.32	22.38	33.95
	(0.52)	(9.87)	(1.41)	(9.60)	(13.08)	(12.66)
Parent and Conflict						
early	0.00	0.00	0.40	2.00	9.28	0.00
	(0.00)	(0.00)	(0.80)	(2.04)	(5.70)	(0.00)
late	0.00	1.08	1.88	2.24	10.18	7.15
	(0.00)	(1.56)	(2.17)	(2.78)	(4.75)	(10.11)
Current and past feeling						
early	0.20	0.72	1.93	7.20	8.88	11.10
	(0.35)	(0.66)	(3.16)	(4.24)	(5.63)	(15.70)
late	0.00	1.50	1.73	4.44	11.05	0.00
	(0.00)	(2.40)	(1.36)	(4.38)	(4.94)	(0.00)

Table 5.82b. Mean Percentage of therapist statements across early and late sessions in which three or more transference referents are linked (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Referents Linked						
Therapist, current feeling and conflict						
early	0.00	2.04	4.65	9.60	7.03	11.10
	(0.00)	(1.53)	(3.45)	(8.42)	(5.73)	(15.60)
late	0.00	0.00	2.47	9.68	18.43	26.80
	(0.00)	(0.00)	(1.96)	(7.84)	(11.23)	(23.49)
Parent, past feeling and conflict						
early	0.00	0.00	0.20	1.70	6.85	0.00
	(0.00)	(0.00)	(0.40)	(1.68)	(3.58)	(0.00)
late	0.00	0.00	0.30	1.58	7.78	0.00
	(0.00)	(0.00)	(0.36)	(2.13)	(5.71)	(0.00)
Therapist, current and past feeling						
early	0.00	0.00	0.75	1.88	2.85	0.00
	(0.00)	(0.00)	(1.19)	(1.99)	(2.33)	(0.00)
late	0.00	0.62	1.35	1.76	6.23	0.00
	(0.00)	(1.38)	(1.42)	(2.51)	(4.84)	(0.00)
Parent, current and past feeling						
early	0.00	0.00	0.63	4.40	7.10	0.00
	(0.00)	(0.00)	(1.25)	(3.46)	(5.49)	(0.00)
late	0.00	1.10	0.65	4.10	9.13	0.00
	(0.00)	(1.55)	(0.58)	(4.22)	(4.11)	(0.00)
Therapist, parent and past feeling						
early	0.00	0.00	0.00	1.06	2.25	0.00
	(0.00)	(0.00)	(0.00)	(1.04)	(1.97)	(0.00)
late	0.00	0.62	0.80	1.76	6.83	0.00
	(0.00)	(1.39)	(0.61)	(2.51)	(5.53)	(0.00)
Therapist, parent and current feeling						
early	0.00	0.00	0.00	1.06	3.30	16.65
	(0.00)	(0.00)	(0.00)	(1.04)	(2.98)	(23.55)
late	0.00	1.44	0.53	2.78	9.70	0.00
	(0.00)	(1.17)	(0.67)	(1.64)	(5.53)	(0.00)
Therapist, parent, current and past feeling						
early	0.00	0.00	0.00	1.06	2.25	0.00
	(0.00)	(0.00)	(0.00)	(1.04)	(1.97)	(0.00)
late	0.00	0.62	0.53	1.76	5.58	0.00
	(0.00)	(1.41)	(0.67)	(2.51)	(4.24)	(0.00)
Therapist, parent, past feeling and conflict						
early	0.00	0.00	0.00	0.00	2.25	0.00
	(0.00)	(0.00)	(0.35)	(0.00)	(1.97)	(0.00)
late	0.00	0.00	0.18	0.68	4.35	0.00
	(0.00)	(0.00)	(0.35)	(1.52)	(3.77)	(0.00)
Therapist, parent, current and past feeling and conflict						
early	0.00	0.00	0.00	0.00	2.25	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(1.97)	(0.00)
late	0.00	0.00	0.18	0.68	4.35	0.00
	(0.00)	(0.00)	(0.35)	(1.52)	(3.77)	(0.00)

Summary

Linking of transference components in therapist statements across early and late sessions

Support was obtained for the hypothesis that therapist linking of explicit references to themselves and current feelings would be higher in late over early sessions of the Psychodynamic grouping of therapies.

Support was not obtained for the hypothesis that therapist linking of explicit references to themselves and current feelings would be lower in late over early sessions of the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that therapist linking of explicit references to themselves, current feelings and conflict would be higher in late over early sessions of the Psychodynamic grouping of therapies.

Support was obtained for the hypothesis that therapist linking of explicit references to themselves, current feelings and conflict would be lower in late over early sessions of the Cognitive-behaviour grouping of therapies.

Therapist linking of explicit references to themselves and current feeling increased in late over early sessions of the Cognitive-behaviour and Psychodynamic groups and decreased in the Psychoanalytic group. The percentage of statements containing such linking was higher in both early and late sessions of the Psychoanalytic and Psychodynamic psychotherapy groups than in the Cognitive-behaviour therapy group.

Therapist linking of explicit references to themselves, current feeling and conflict increased in late over early sessions of the Conversational, Psychodynamic and Psychoanalytic psychotherapy groups and decreased in the Cognitive-behaviour and Cognitive therapy groups. The percentage of statements containing such linking was higher in both early and late sessions of the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups.

5.5 RESULTS SUMMARY - THE OCCURRENCE OF TRANSFERENCE REFERENCES ACROSS THERAPIES

The results of the analyses of patient and therapist references to transference components which have been detailed in this chapter are summarised in the tables beneath. These summaries itemise whether or not each of the various comparisons analysed showed a significant difference across the two therapy groupings and across the six therapy groups.

Table 5.83a presents a summary of comparisons of patient references and Table 5.83b of therapist references to individual transference components where the main effect analysed was type of therapy. Table 5.84 summarises comparisons of summated transference references, and Table 5.85 of the linking together of transference references, both also across type of therapy.

Table 5.86 presents a summary of comparisons of patient and therapist references to individual transference components where the main effect analysed was the interaction of session order and type of therapy. Finally, Table 5.87 summarises the effect of the interaction of session order and type of therapy on the linking of transference references.

Table 5.83a Summary of Results of Comparisons Across the Two Therapy Groupings and the Six Therapy Groups of Patient References to Individual Transference Components

	Two Therapy Groupings			Six Therapy Groups		
Reference	Rate	Mean	Percent.	Rate	Mean	Percent.
Pt. explicit to:						
therapist	Sig.	-	Sig.	Sig.	-	Sig.
parent	Sig.	-	Sig.	Sig.	-	Sig.
current feeling	Sig.	-	Sig.	N.S.	-	Sig.
past feeling	N.S.	-	Sig.	Sig.	-	Sig.
conflict	Sig.	-	Sig.	Sig.	-	Sig.
Pt. implicit to:						
therapist	N.S.	-	Sig.	Sig.	-	Sig.
parent	Sig.	-	Sig	Sig.	-	Sig.
current feeling	N.S.	-	Sig.	Sig.	-	N.S.
past feeling	Sig.	-	Sig.	N.S.	-	N.S.
conflict	N.S.	-	Sig.	N.S.	-	Sig.
Pt. ratio of explicit to implicit to:						
therapist	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.
parent	-	N.S.	N.S.	-	Sig.	Sig.
current feeling	-	N.S.	Sig.	-	N.S.	N.S.
past feeling	-	N.S.	N.S.	-	Sig.	N.S.
conflict	N.S.	N.S.	N.S.	Sig.	N.S.	N.S.

Table 5.83b Summary of Results of Comparisons Across the Two Therapy Groupings and the Six Therapy Groups of Therapist References to Individual Transference Components

	Two Therapy Groupings			Six Therapy Groups		
Reference	Rate	Mean	Percent.	Rate	Mean	Percent.
Th. explicit to:						
therapist	Sig.	-	Sig.	Sig.	-	Sig.
parent	Sig.	-	Sig.	Sig.	-	Sig.
current feeling	Sig.	-	Sig.	Sig.	-	Sig.
past feeling	Sig.	-	Sig.	Sig.	-	N.S.
conflict	Sig.	-	Sig.	Sig.	-	Sig.
Th. implicit to:						
therapist	N.S.	-	N.S.	N.S.	-	Sig.
parent	N.S.	-	Sig.	N.S.	-	N.S.
current feeling	N.S.	-	N.S.	Sig.	-	N.S.
past feeling	Sig.	-	Sig.	Sig.	-	Sig.
conflict	Sig.	-	Sig.	Sig.	-	Sig.

Table 5.84 Summary of Results of Comparisons Across the Two Therapy Groupings and the Six Therapy Groups of Summated Transference References

	Two Therapy Groupings			Six Therapy Groups		
Reference	Rate	Mean	Percent.	Rate	Mean	Percent.
Patient:						
Explicit	Sig.	Sig.	-	Sig.	Sig.	-
Implicit	N.S.	Sig.	-	Sig.	Sig.	-
Expl. & Impl.	Sig.	Sig.	-	Sig.	Sig.	-
Therapist:						
Explicit	Sig.	Sig.	-	Sig.	Sig.	-
Implicit	Sig.	Sig.	-	Sig.	Sig.	-
Expl. & Impl.	Sig.	Sig.	-	Sig.	Sig.	-

Table 5.85 Summary of Results of Comparisons Across the Two Therapy Groupings and the Six Therapy Groups of Linking of Transference References

Reference	Two Therapy Groupings Percentages		Six Therapy Groups Percentages	
	Explicit	Explicit & Implicit	Explicit	Explicit & Implicit
Patient:				
par& pf	Sig.	Sig.	N.S.	Sig.
th & cf	Sig.	Sig.	Sig.	Sig.
cf & con	Sig.	Sig.	Sig.	Sig.
par & con	Sig.	Sig.	N.S.	Sig.
cf & pf	Sig.	Sig.	Sig.	Sig.
th, cf & con	Sig.	Sig.	Sig.	Sig.
par, pf & con	N.S.	Sig.	N.S.	Sig.
th, cf & pf	Sig.	Sig.	Sig.	Sig.
par, cf & pf	Sig.	Sig.	N.S.	Sig.
th, par & pf	N.S.	Sig.	Sig.	Sig.
th, par & cf	Sig.	Sig.	Sig.	Sig.
th, par, cf & pf	N.S.	Sig.	N.S.	Sig.
th, par, pf & con	N.S.	Sig.	N.S.	Sig.
th, par, cf, pf &con	N.S.	Sig.	N.S.	Sig.
Therapist:				
par& pf	Sig.	Sig.	N.S.	Sig.
th & cf	Sig.	Sig.	Sig.	Sig.
cf & con	Sig.	Sig.	Sig.	Sig.
par & con	Sig.	Sig.	Sig.	Sig.
cf & pf	Sig.	Sig.	N.S.	Sig.
th, cf & con	Sig.	Sig.	Sig.	Sig.
par, pf & con	Sig.	Sig.	Sig.	Sig.
th, cf & pf	Sig.	Sig.	N.S.	Sig.
par, cf & pf	Sig.	Sig.	Sig.	Sig.
th, par & pf	N.S.	Sig.	N.S.	Sig.
th, par & cf	Sig.	Sig.	N.S.	Sig.
th, par, cf & pf	N.S.	Sig.	N.S.	Sig.
th, par, pf & con	N.S.	Sig.	N.S.	Sig.
th, par, cf, pf &con	N.S.	Sig.	N.S.	Sig.

Note. th = therapist, par = parent, cf = current feeling, pf = past feeling, con = conflict

Table 5.86 Summary of Results of Comparisons of the Interaction of Session Order and Type of Therapy on References to Individual Transference Components

	Two Therapy Groupings			Six Therapy Groups		
Reference	Rate	Mean	Percent.	Rate	Mean	Percent.
Pt. explicit to:						
therapist	N.S.	N.S.	N.S.	N.S.	N.S.	Sig.
parent	N.S.	N.S.	N.S.	N.S.	N.S.	Sig.
current feeling	Sig.	Sig.	N.S.	N.S.	N.S.	N.S.
past feeling	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
conflict	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Pt. implicit to:						
therapist	N.S.	N.S.	N.S.	Sig.	Sig.	N.S.
parent	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
current feeling	N.S.	N.S.	N.S.	Sig.	Sig.	Sig.
past feeling	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
conflict	N.S.	N.S.	N.S.	N.S.	Sig.	Sig.
Th. explicit to:						
therapist	N.S.	N.S.	N.S.	N.S.	N.S.	Sig.
parent	N.S.	N.S.	N.S.	Sig.	N.S.	N.S.
current feeling	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
past feeling	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
conflict	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Th. implicit to:						
therapist	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
parent	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
current feeling	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
past feeling	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
conflict	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.

Table 5.87 Summary of Results of Comparisons of the Interaction of Session Order and Type of Therapy on Linking of Transference References

Reference	Two Therapy Groupings Percentages		Six Therapy Groups Percentages	
	Explicit	Explicit & Implicit	Explicit	Explicit & Implicit
Patient:				
par& pf	N.S.	N.S.	N.S.	N.S.
th & cf	N.S.	N.S.	Sig.	N.S.
cf & con	N.S.	N.S.	N.S.	N.S.
par & con	N.S.	N.S.	N.S.	N.S.
cf & pf	N.S.	N.S.	N.S.	N.S.
th, cf & con	Sig.	N.S.	N.S.	N.S.
par, pf & con	N.S.	N.S.	N.S.	N.S.
th, cf & pf	N.S.	N.S.	N.S.	N.S.
par, cf & pf	N.S.	N.S.	N.S.	N.S.
th, par & pf	N.S.	N.S.	N.S.	N.S.
th, par & cf	N.S.	N.S.	N.S.	N.S.
th, par, cf & pf	N.S.	N.S.	N.S.	N.S.
th, par, pf & con	N.S.	N.S.	N.S.	N.S.
th, par, cf, pf &con	N.S.	N.S.	N.S.	N.S.
Therapist:				
par& pf	N.S.	N.S.	N.S.	N.S.
th & cf	N.S.	N.S.	Sig.	N.S.
cf & con	N.S.	N.S.	N.S.	N.S.
par & con	N.S.	N.S.	N.S.	N.S.
cf & pf	N.S.	N.S.	N.S.	N.S.
th, cf & con	Sig.	N.S.	Sig.	N.S.
par, pf & con	N.S.	N.S.	N.S.	N.S.
th, cf & pf	N.S.	N.S.	N.S.	N.S.
par, cf & pf	N.S.	N.S.	N.S.	N.S.
th, par & pf	N.S.	N.S.	N.S.	N.S.
th, par & cf	N.S.	N.S.	N.S.	N.S.
th, par, cf & pf	N.S.	N.S.	N.S.	N.S.
th, par, pf & con	N.S.	N.S.	N.S.	N.S.
th, par, cf, pf &con	N.S.	N.S.	N.S.	N.S.

Note. th = therapist, par = parent, cf = current feeling, pf = past feeling, con = conflict

5.6 DISCUSSION

5.6.1 Patients' Transference References

Explicit and Implicit References to Individual Transference Components

Explicit references to transference components were higher in the Psychodynamic grouping than the Cognitive-behaviour grouping and in the Psychoanalytic and Psychodyamic psychotherapy groups than in the other four therapy groups. Thus for example, only 4% of patient statements in the cognitive-behaviour grouping contained explicit references to the therapist compared with 31% in the psychodynamic grouping, only 6% to conflict compared with 21%, and only 2% to past feeling compared with 8%. Although, as in the pilot study (Chapter Two), there was not any significant difference between the individual therapy groups in explicit references to current feeling, there was a higher level of such references in the Psychodynamic grouping of therapies than the Cognitive-behaviour grouping.

The pilot study (Chapter Two) had hypothesised that implicit transference references, unlike explicit, would occur equally across therapy groups. It was argued that although patient references to transference components would not be facilitated by cognitive-behaviour therapists they would nonetheless seek and find expression implicitly. However general support was not forthcoming for this. Instead implicit references were higher in the Psychodynamic grouping of therapies than the Cognitive-behaviour. This finding was replicated in the present study. It suggests that psychodynamic psychotherapies, in working to create a therapeutic environment refined for the exploration of the patient's internal world and the transferential relationships derived from it, facilitate and intensify implicit as well as explicit expressions of transference in a way that cognitive-behaviour therapies do not. This is not to say that because cognitive-behaviour therapies do not tend to focus on transferential material that patients in these therapies do not tend to express it. As noted above patients in <u>all</u> therapies made transference references. Nor is it to say that if explicit references to transference components are not facilitated by therapists that there will not be implicit references made by patients. Indeed, analyses showed a high level of implicit references about the therapist or therapy in cognitive-behaviour therapies compared with explicit references. Overall patients in the cognitive-behaviour grouping of therapies made nearly four times as many statements containing implicit references about the therapist or therapy than explicit references (15% of all statements as against 4%), whereas in the psychodynamic psychotherapies there was no difference in the level of explicit and implicit references. In the behaviour therapy group only 1.5% of patient statements contained such references explicitly stated against 6.5% implicitly stated, in the cognitive-behaviour group only 4.5% explicitly against 22% implicitly, and in the cognitive group 6% explicitly against 19% implicitly. This raises for consideration that implicit

references about the therapist are more frequent in psychological therapies, and in particular cognitive-behaviour therapies, than is commonly recognised. A number of factors point to the importance of therapists of all theoretical orientations monitoring this covert as well as the overt patient narrative for strains and ruptures in the therapeutic alliance and addressing these. It is probable that negative feelings about therapy are more usually expressed covertly (cf. Gill and Hoffman, 1982) and a further part of this study, as is noted later, found a significant level of patient implicitly expressed negative material, in particular in cognitive-behaviour therapies. To so monitor and address interpersonal tension in the patient-therapist relationship may lessen premature termination (cf. Roth and Fonagy, 1996). In addition accumulated research now shows a significant impact of the therapeutic alliance on outcome, with around 20 to 25% variance in outcome accounted for by it (e.g. Gaston, Marmar, Gallagher and Thompson, 1991; Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins and Pilkonis, 1996; and Marmar, Gaston, Gallagher and Thompson, 1989). Further consideration is given to this later in discussing therapist response to negative patient material.

Summated Transference References and Linking of References to Components

The psychodynamic grouping of therapies had higher summated explicit, implicit, and combined explicit and implicit ratings per patient statement than the cognitive-behaviour grouping, and the psychoanalytic and psychodynamic psychotherapy groups higher than the other four groups. Eighty-five percent of patient statements in the psychodynamic grouping compared to 68% in the cognitive-behaviour explicitly referred to at least one transference component, 40% compared to 7% to at least two, 8% compared to less than 1% to at least three, and 2% compared to 0.01% to all four components. This pattern of the two groupings' relative percentages of explicit references was not markedly different for implicit and combined explicit and implicit references. Thus, as with the implicit references to individual transference components discussed above, analysis of summated transference references did not generally show support for the premise that because explicit transference references would not be facilitated in cognitive-behaviour therapies they would seek expression implicitly.

The majority of the permutations of linking of transference components occurred significantly more often in the psychodynamic grouping of therapies than the cognitive-behavioural. This included, as expected, linking of therapist and current feeling, current feeling and conflict, and therapist, current feeling and conflict, with analyses across the six therapy groups also showing these occurred more in the psychoanalytic and psychodynamic psychotherapy groups than in the behaviour, cognitive-behaviour and cognitive groups. A defining feature of psychodynamic psychotherapies is the exploration of the transferential, patient-therapist, relationship and the

present study's findings provided evidence of this happening in the consulting room. Another defining feature of psychodynamic psychotherapies is the genetic transference interpretation, the making of links between the current relationship with the therapist and past, formative, relationships, in particular with parents. Therefore, as expected, explicit links by patients of combinations of past feelings, current feelings, therapist and parent also occurred more in the psychodynamic grouping than in the cognitive-behaviour grouping. However it had also been argued that short term psychodynamic psychotherapy was a more "cognitive" process than long term, more intensive, psychoanalytic psychotherapy and that it would involve more of an emphasis on genetic transference interpretations (cf. Malan, 1979). It had therefore been expected that the psychodynamic psychotherapy group would have a higher occurrence than the psychoanalytic of linking of combinations of past feelings, current feelings, therapist and parent. This did not occur (though the psychodynamic grouping had a higher occurrence than the cognitive-behaviour of linking current and past feeling). This finding does not provide support for the proposal that psychoanalytic psychotherapy works more in the here and now relationship with the therapist and the fantasies, conflicts and defences aroused by it, and that short term psychodynamic psychotherapy more in the building of a framework of understanding current difficulties in the light of earlier life relationships.

Thus patients in both psychodynamic and cognitive-behaviour therapies made explicit and implicit references to each of the transference components and also statements linking together all transference components. However these references, excepting those to current feelings, were significantly higher in psychodynamic psychotherapies.

5.6.2 Therapists' Transference References

Explicit and Implicit References to Individual Transference Components

Therapists in all therapy groups referred explicitly to all transference references, though the occurrence of these was higher in the psychodynamic grouping of therapies than the cognitive-behaviour. The higher occurrence of explicit references to current feelings and thoughts in psychodynamic therapies was unexpected. Such references occurred in 68% of statements against 40% in the cognitive-behaviour grouping, and their rate of reference (the occurrence per line of narrative) was 0.48 against 0.18 in the cognitive-behaviour grouping. This was unexpected because of the theoretical focus of cognitive-behaviour therapies on current thoughts. In this study, analyses across the six therapy groups showed this lower occurrence was not explained by the predictably low references to current feelings and thoughts in the behaviour therapy group and that references were significantly higher in the psychoanalytic and psychodynamic psychotherapy

groups than other groups. For example 23% of therapist statements in behaviour therapy included explicit references to current feelings and thoughts, 52% in cognitive-behaviour and 48% in cognitive, against 70% in conversational therapy, 68% in psychodynamic and 65% in psychoanalytic. A similar picture was shown by rate of reference data: 0.17 in the behaviour therapy group, 0.20 in the cognitive-behaviour and 0.18 in the cognitive, against 0.36 in the conversational, 0.47 in the psychodynamic and 0.58 in the psychoanalytic.

Contrary to these findings Kerr et al (1989) found a higher number of references to current thoughts and feelings in cognitive-behaviour therapy than in psychodynamic. They also found there was no significant difference between cognitive-behaviour and psychodynamic therapies in references to the therapist. The present study however found a higher occurrence of explicit references to the therapist, and to conflict too, in the psychodynamic grouping and the psychoanalytic and psychodynamic psychotherapy groups. This had been expected because of the theoretical centrality to psychodynamic therapies of exploration of the transferential patient-therapist relationship, including to throw light on other interpersonal difficulties and on intrapersonal conflict. The finding also suggests that therapist feedback to patients in cognitive-behaviour therapies on how they interpret what others say and do, infrequently focuses on the other being the therapist. Thus little use is made of this therapeutic potential in the patient-therapist relationship.

Therapist explicit references to parents and to past feelings were higher in the psychodynamic grouping than the cognitive-behaviour, replicating findings of the pilot study (Chapter Two) and of Kerr et al (1989). Of note though was that the psychodynamic psychotherapy group but not the psychoanalytic contained more therapist explicit references to parents and to past feelings than did the three cognitive-behaviour groups. This contrasts with patient references to parents and past feelings where there was no difference between the psychodynamic and psychoanalytic groups and therefore no support for the view that there is a primary mutative process in short-term psychodynamic psychotherapy, but not in psychoanalytic psychotherapy, of the construction of an understanding of current interpersonal and intrapersonal difficulties as being derived from conflictual early life relationships. The possibility is therefore raised that psychodynamic psychotherapists (working in once weekly time limited psychotherapy) do indeed, as hypothesised, suggest to their patients, even if patients do not reciprocate to the same degree, an understanding of current life experience including of conflict as being derived from early life relationships and conflict. Psychoanalytic psychotherapists on the other hand (working in three times weekly open ended psychotherapy) may focus more on the exploration of the internal world of the patient as it impacts on the patient-therapist relationship.

Therapists' implicit references to conflict, to parents, and to past feelings were all higher in the psychodynamic grouping of therapies than the cognitive-behaviour grouping. The references to conflict were also higher in the psychodynamic and psychoanalytic psychotherapy groups, and the references to past feelings higher in the psychodynamic psychotherapy group than the behaviour, cognitive-behaviour and cognitive therapy groups.

But what is the nature of therapists' implicit references ? Are they deliberate but indirect or tentative encouragement, a hook, for the patient to make a link with and begin to talk about what they implicitly refer to ? Or are they utterances the significance of which the therapist is unaware, an unconscious resonance, a countertransference to the content of the patient's narrative and about the patient, or a countertransference derived from unresolved issues in the therapist stirred by the patient ? Or are they an irrelevance ? It is probable that across the range of psychological therapies therapists do make comments the significances of which they are unaware. However, therapists' implicit references to parents, past feelings and conflict were all higher in the psychodynamic grouping of therapies and in particular the psychodynamic psychotherapy group and thus mirror the picture with regard to therapists' explicit references. This provides some credence, at least in that group of therapies, for at least some of these implicit references being conscious and deliberate attempts by therapists to facilitate the expression and exploration of difficult aspects of the patients' self and/or life experience which may be disavowed or unconscious. Or as Menninger and Holzman (1973) lightly put it "one "tells" a patient what the patient *almost* sees for himself, that is, when he almost knows what he doesn't know he knows, and one tells him in such a way that the patient, not the analyst, takes the "credit" for the discovery." (p.136).

Summated Transference References and Linking of References to Components

The psychodynamic grouping of therapies had a higher number of different transference components referred to explicitly, implicitly, and explicitly and implicitly combined per therapist statement and per line of therapist statement than did the cognitive-behaviour grouping of therapies. The psychodynamic and psychoanalytic psychotherapy groups also had a higher number of summated explicit, and explicit and implicit combined references than the three cognitive-behaviour therapies. However, whilst the psychodynamic psychotherapy group also had a higher number of summated implicit references the picture was more complex with the psychoanalytic psychotherapy group which only had a higher number than the behaviour therapy group. Inspection of data showed its low number of summated implicit references to be attributable to its low number of individual implicit references to parents, to current feelings and to past feelings. This, along with the high rate of its individual implicit references to the therapist and to conflict, suggests that implicit references linking the therapist and conflict were more common in therapist

statements in the psychoanalytic psychotherapy group than the linking of other implicit references. Future research will consider this possibility further by analysing therapist linking of implicit references to transference components. Again, as with therapists' implicit references to individual transference components, it raises some support for the view that psychoanalytic practitioners are consciously making implicit references to themselves and conflict to carefully facilitate patients' expression and exploration of aspects of the patient-therapist relationship.

Although the rates of summated explicit and summated combined explicit and implicit patient references to transference components were higher in the cognitive-behaviour grouping of therapies than in the psychodynamic, the comparative therapist rates were lower than in the psychodynamic grouping. This suggests, in line with pilot study (Chapter Two) findings, that therapists in cognitive-behaviour therapies responded less fully to patients' references.

As hypothesised, therapists in the psychodynamic grouping of therapies had significantly higher linking of transference components of all sorts. Therapists in the psychodynamic psychotherapy group made more statements than therapists of other groups, including the psychoanalytic, which linked past feelings and parent and current feelings and therapist, with and without conflict. This was expected and was in line with findings with respect to references by psychodynamic psychotherapists to individual transference components. It was contrary to Olsson's (1988) finding of few links in psychodynamic psychotherapy of current feeling to the therapist to past feeling to parent, with her instead finding links being made to unspecified others. Such use of 'general others' might be more expected of a cognitive-behaviour therapy and in Olsson's study may reflect the use of inexperienced psychodynamic psychotherapists and a limited data set.

The psychoanalytic and psychodynamic psychotherapy groups, but not the conversational, had significantly more linking than the behaviour, cognitive-behaviour and cognitive groups of therapist and current feeling, current feeling and conflict, and therapist, current feeling and conflict. This is of course a defining feature of psychodynamic therapies, the exploration of the transferential relationship, and this study's findings provided support that therapists did so.

There was evidence that patients in the psychoanalytic psychotherapy group made more links between past and present, that is between past and present feelings, and between parents and the therapist than did their therapists. There was also some evidence that therapist focus in the psychoanalytic psychotherapy group was, more than was patients', on in-session feelings and thoughts. This points to a need for skilled, timed and judicious use of transference interpretations so that they have mutative value rather than being potentially undermining of the patient and the

patient-therapist relationship; as may (cf. Piper, 1991), for example, repeated and continuous interventions like:

> when you talk of your feelings about your father what you are really saying is how you feel about me
>
> you see, when you talk about the difficult journey here today what you are actually saying is how difficult you are finding the process of therapy.

The links that were being made between past and present were not ones of the undoing of repression and the making conscious forgotten experiences. A diminishing number of psychoanalysts today would so see the primary mutative process of psychotherapy to be the recall and reconstruction of early traumatic memories and their working through as documented in Freud's paper (1914a) *Remembering, Repeating and Working-Through.* Indeed, Fonagy (1999) has recently stated that "there is no evidence for this and in my view to cling to this idea is damaging to the field" (p.215). He notes Stern, Sander, Nahum, Harrison, Lyons-Ruth, Morgan, Bruschweiler-Stern and Tronick's (1998) proposal that the early experiences contributing to representations of object relations will in any case have mostly occurred too early in life to be recalled as autobiographical memory. These early life experiences are nonetheless formative and impact on patients' current relationships with themselves and others, including on the patient-therapist relationship. Fonagy also refers to Joseph (1985), quoting her important point that in our exploring and understanding with patients their current lives and difficulties that:

> if we work only with the part that is verbalised, we do not really take into account the object relationships being acted out in the transference (p.448).

What Joseph is pointing to here is that early object relations may become part of a memory that does not require conscious recollection but drives current relationships in a generally unthinking and unknowing way. We do not know much of why we act, think and feel in the way we do, nor what caused us to do so. But we do have unconscious expectations about ourselves and others, procedures, which organise our interpersonal behaviour (cf. Power, 1997). Stern et al (1998) refer to two kinds of memory; explicit (declarative) and implicit (procedural). Declarative knowledge is conscious or readily accessible to consciousness. Procedural knowledge is of implicit relational knowing which integrates affect, cognition and behaviour. It has been a central concept in the developmental psychology of pre-verbal infants and many researchers have documented that infants interact with parents on the basis of this implicit relational knowing (Sander, 1988; Stern, 1985; Lyons-Ruth, 1991). Therapists can access these procedures, and draw patients attention to them and their dysfunctional aspects, by attending not just to patients' narratives about themselves

and their current lives but also by attending to how patients impact on them in the consulting room. Fonagy (1999) describes this process as 'the conscious elaboration of preconscious relationship representations, principally through the analyst's attention to the transference.' (p.218). It is this, rather than the recovery of previously forgotten experience, that has become a central part of the endeavour of psychodynamic psychotherapists. The gaining of insight into what Meissner (1991) describes as 'belief systems... that influence the patient's interaction with the world.' (p.179), may be seen as a major if not the major mutative factor shared across psychodynamic psychotherapies. The links made between past and present in the psychodynamic therapies come primarily from this, the belief that early life experiences structure internal object relationships which then mediate current experience of the world and of self, and how we think, feel and behave. There is some evidence from the present study that in engaging in this mutative process psychodynamic psychotherapists place a little more emphasis on the early life experience and that psychoanalytic psychotherapists place a little more emphasis on the current experience.

In line with this Gill (1982) helpfully suggests two types of therapist transference interpretations. First, interpretation of patient resistance to the awareness of transference and, second, interpretation of patient resistance to the resolution of transference. He suggests the former involves interpretation of implicit, unconscious, transference references and the latter interpretation of explicit transference references. The former is intended to make implicit references explicit, whilst the latter is intended to facilitate the patient's understanding of the genesis of the transference. Gill argues that not only is insufficient emphasis given in psychotherapy to interpretation of implicit transference references but also that interpretations to resolve transference, rather than being primarily genetic, should be in the here and now; the patient's experience of the therapist and therapy. He sees a primary reason for a failure to adequately address transference issues is the avoidance of affect laden conflict. An avoidance by patient and therapist of the patient's interpersonal enactment with the therapist of conflictual aspects of their internal world derived from early life formative experiences.

This concept of an internal structure mediating our expectations and experience of the world and of ourselves and underpinning transference phenomena is, as was discussed in Chapter One, one which is shared in principle by cognitive-behaviour therapists and explored by them too; but not within the patient-therapist relationship. Freud, as he described in his case history of Dora (1905), saw this task as a relatively easy one "he that has eyes to see and ears to hear may convince himself that no mortal can keep a secret." (p. 114). The psychoanalysts and psychotherapists of today would be more reticent; sometimes unconscious meaning is clear but often it is not and one engages over time in looking for converging evidence before offering meaning in the form of a

tentative interpretation. Furthermore as Macalpine (1950) noted "... the resolution itself of psychoanalytic transference is not understood in all its aspects. True enough, its manifestations are continually analysed in psychoanalysis and an attempt is made to reduce them, but its ultimate resolution or even its ultimate fate is not clearly understood." (p.537). If transference is a universal psychical function it will not be excised through the analytic process; rather its symptomatic, conflictual and historical content may be adapted or resolved. Aspects of these processes of patient and therapist transference references are considered further, across early and late therapy sessions, in a following section.

In summary, therapists in both psychodynamic and cognitive-behaviour therapies made explicit and implicit references to, with one exception, each of the transference components. The exception was that there were no implicit references to parents made by therapists in the behaviour therapy group. The occurrence of these references, however, was significantly higher in psychodynamic therapies. In addition, therapists in the psychodynamic psychotherapies made frequent statements linking together various possible combinations of individual transference components including linking them all. In contrast, therapists in the cognitive-behaviour therapies made significantly less statements linking individual components and never linked all components. It seems probable that the interventions of psychodynamic psychotherapists created an environment that facilitated both a higher expression of transference references by patients and their exploration.

5.6.3 Comparison of Transference References Across Early and Late Therapy Sessions

Patient References

Inspection of data in the pilot study (Chapter Two) had suggested that both explicit and implicit patient references to transference components increased in late over early sessions of cognitive-behaviour therapies. There was therefore no support for the hypothesis that explicit references would lessen in late sessions of cognitive-behaviour therapies because they would not be attended to by therapists and that as a result implicit references would increase. In the present study there were, with two exceptions, no significant differences in references across early and late sessions. These exceptions were an increase in late sessions over early of explicit references to current feelings and thoughts in the cognitive-behaviour grouping of therapies and of implicit references to conflict in the cognitive-behaviour therapy group. Lack of support for the hypothesis was therefore replicated; though two caveats are mooted. Firstly, the cognitive-behaviour grouping showed non-significant reductions in explicit references to transference components apart from to current feelings and thoughts, with this most marked in the behaviour therapy group. It also showed a non-

significant increase in implicit references to conflict and the behaviour and cognitive-behaviour therapy groups showed an increase in implicit references to the therapist. This suggests a possible need for further research with a larger sample size before categorical rejection of the hypothesis. Secondly, rather than a reduction in explicit references and an increase in implicit references to individual components, there could be a reduction in linking of explicit references and an increase in linking of implicit references. Certainly the cognitive-behaviour grouping tended to show a decrease in late sessions over early of linking of explicit references. There was though a notable exception to this; a non-significant increase in linking of references to therapist, current feeling and conflict which occurred in the context of a decrease in references linking current feeling and conflict. This suggests the possibility that whilst patients' explicit references to transference components were not pursued by cognitive-behaviour therapists and that generally patient explicit references to individual components and their linking of such references did not increase there was an increase in patients' explicit expression of conflictual feelings or thoughts about the therapist or therapy.

Inspection of data in the pilot study (Chapter Two) had also suggested an increase in explicit references and a decrease in implicit in late sessions over early of the psychodynamic therapies. This provided some tentative support for the declared process in these the therapies of making conscious that which is unconscious by interpretation of the latent meaning within patient narratives (cf. Graff and Luborsky, 1977). Clear support for this process was not forthcoming in the present study. Although summated explicit references were higher and summated implicit lower in late sessions over early of the psychodynamic grouping of therapies neither were significant.

As noted above the small sample sizes in early versus late session analyses may mitigate against finding significant differences. But, furthermore, the aim of psychodynamic psychotherapists to make implicit material explicit may be achieved by an increased openness and recognisability of transference by the patient (cf. Luborsky et al, 1979). A more pertinent indicator of this may be an increase in linking of explicit references and a decrease in linking of implicit references. Linking of implicit references across early and late sessions was not analysed. However, the majority of possible links of explicit references to transference components, including of all five components, did increase in late over early sessions of the psychodynamic grouping of therapies.

Of the three psychodynamic psychotherapies only the psychoanalytic showed a statistically significant increase in late sessions of summated explicit references and a significant decrease in summated implicit references. Inspection of data though did suggest that all three groups saw an

increase in linking of explicit references in late sessions. However, whilst in the psychoanalytic group this included an increase in linking of four or all five components, in the psychodynamic group the increase was in linking of smaller numbers of components, and in the conversational group of still smaller numbers still.

Therapist References

Explicit references by therapists to themselves and their linking of explicit references to themselves and current feelings and to themselves, current feelings and conflict increased in late sessions over early of the psychodynamic grouping of therapies. The increases predominantly reflected therapist activity in the psychodynamic group and to a lesser extent the psychoanalytic. These findings, along with the patient linking of transference references detailed above, suggest that therapists in the three psychodynamic psychotherapies tended to pick up more on patients' conflictual feelings and thoughts about them than their non-conflictual feelings and thoughts.

Therapist linking of explicit references to the therapist and current feeling, with and without conflict, decreased in late sessions over early of the cognitive-behaviour grouping of therapies. Whilst patient linking of explicit references to the therapist and current feeling also fell, patient linking of explicit references to the therapist, current feeling and conflict actually increased. This finding is in line with pilot study findings (Chapter Two) that patient references about conflictual aspects of the patient-therapist relationship were not fully responded to by cognitive-behaviour therapists.

5.6.4 Measures of Percentage, Mean and Rate

Whereas the pilot study (Chapter Two) had only analysed measures of the percentage of statements in sessions containing various transference references, this chapter has also analysed measures of the mean occurrence per statement and the mean occurrence per line (rate) of references.

Descriptive data on therapy sessions (see pages 87-90) showed those in the cognitive-behaviour grouping of therapies to have a greater mean length in minutes and a greater mean length in words than those in the psychodynamic grouping. The cognitive-behaviour sessions also contained a greater mean number of patient and therapist statements than psychodynamic sessions and the mean length in words of each of these therapist statements was greater. The mean length in words of each patient statement was greater in the psychodynamic grouping of therapies.

Measures of percentages, means and rates are each valid and bring a breadth of perspectives to the sessional material. However, measures of rate have an advantage over measures of percentage and mean in that they control for differences between therapy groups in statement and session length. Therefore in the following two chapters only the results of analyses of measures of rates are presented in the main text, unless there are significant differences between these and analyses of percentages and means. Analyses of percentages and means are presented in full in Appendix 8.

CHAPTER 6

RESULTS

THE FOCUS OF THERAPISTS' INTERVENTIONS

This chapter presents results of the analysis of therapists' references to each of the individual categories of the Coding System of Therapeutic Focus. Data are presented first which give information on the reliability of the coding of these references. Results are then presented of where the main effect analysed was the type of therapy. These are then followed by results in which the main effect analysed was the interaction of the type of therapy with session order i.e the comparison across therapies of sessions from early in therapy with those from late in therapy.

In investigating the effect of therapy type analyses were undertaken across the six therapy groups: behaviour, cognitive-behaviour, cognitive, conversational, psychodynamic and psychoanalytic and also across the two therapy groupings: cognitive-behaviour (behaviour, cognitive-behaviour and cognitive) and psychodynamic (conversational, psychodynamic and psychoanalytic).

In investigating the effect of session order the unit of analysis was the specific patient-therapist pair. Thus, sessions from early in therapy of a patient-therapist pair were compared with sessions from late in the same therapy. The early sessions were taken from the first five sessions of therapy but not the first and compared with late sessions taken from the last five sessions of therapy but not the last. The one exception to this was late sessions of psychoanalytic psychotherapy where sessions were taken from the last two months of therapies all of which exceeded two years.

Each component of the Coding System of Therapeutic Focus was considered from the perspective of:

i) percentage - the percentage of statements in sessions in which the therapist focuses on the component

ii) mean - the mean number of separate occasions per therapist statement of the therapist focusing on the component

iii) rate - the mean number of separate occasions per line of narrative of the therapist focusing on the component

However, as noted at the end of Chapter Five, measures of rate have the advantage of controlling for differences in statement and session length between therapy groups. There was also limited variation between the three measures in the differences they identified in comparisons of transference references between therapy groups. Therefore only the results of analyses of measures of rates are presented in the main text, unless there are significant differences between these and analyses of percentages and means. Analyses of percentages and means are presented in full in Appendix 9.

6.1 Reliability of Coding System of Therapeutic Focus Ratings

Twelve transcriptions of therapy sessions included in the study and rated by the author were selected to assess the interrater reliability of the Coding System of Therapeutic Focus. Using a stratified random sampling technique two transcriptions were randomly taken from each of the six stratum (therapy groups) researched. These 12 sessions were then rated by an independent rater, a National Health Service psychotherapist with 17 years post qualification experience who was trained in cognitive-behaviour and psychodynamic therapy. Prior to undertaking the rating he was trained in the use of the coding system. This training included familiarisation with the system's Training and Rater's manuals, conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings of transcriptions not used in the study followed by discussion meetings with the author. The ratings showed good reliability with high percentage agreements between raters overall and on each individual category of the system. These percentage agreements are presented in Table 6.1a and 6.1b. The levels of percentage agreement achieved suggested good reliability and an absence of bias in the author's ratings.

6.2 Comparison of Coding Categories across Therapies

Therapists' focus on the various coding categories of the Coding System of Therapeutic Focus were analysed by type of therapy.

6.2.1 Components of Patient Functioning

This section of analyses includes testing of the hypotheses that:

i) the Psychodynamic grouping of therapies will contain a higher number of references to emotions than the Cognitive-behaviour grouping

Table 6.1a. Percentage Agreement between Raters of Therapist References to Components of Patient Functioning, General Interventions, Intrapersonal links and Interpersonal links

Category	Agreement	Disagreement
Comp.of Pt. Functioning:		
Situation	83.3	16.7
Self Observation	82.6	17.4
Self Evaluation	84.2	15.8
Expectations	86.0	14.0
General Thoughts	89.6	10.4
Intentions	83.4	16.6
Emotions	91.1	8.9
Actions	87.6	12.4
Gen.Interventions:		
Real-Unreal.	81.7	18.3
React.of Other	80.8	19.2
Theme	84.8	15.2
Support	89.2	11.9
Info. Giving	93.1	6.9
Changes	86.6	13.4
Avoidance	87.4	12.6
Self Disclosure	88.8	11.2
Intrapersonal Links:		
Sim/Patterns	82.5	17.5
Differences	85.3	14.7
Vicious Cycle	87.1	12.9
Consequences	87.3	12.7
Interpersonal Links:		
Patterns	83.1	16.9
Vicious Cycle	85.9	14.1
Dir.of Cons:		
pt.to other	90.6	9.4
other to pt.	84.7	15.3
Comp/Contrasts	83.6	18.4
Gen.Interaction	87.7	12.3

Table 6.1b. Percentage Agreement between Raters of Therapist References to Persons Involved, Time Frames, Person Links and Time Links

Category	Agreement	Disagreement
Persons Involved:		
Patient	90.9	9.1
Therapist	90.7	9.3
Parent	93.3	6.7
Mate	93.1	6.9
Child	92.6	7.4
Dream Figure	86.4	13.6
Others	87.3	12.7
Time Frames:		
Pre-Adult Past	81.6	18.4
Adult Past	87.4	12.6
Current	92.4	7.6
In Session	91.1	8.9
Future	87.7	12.3
General	80.2	19.8
Irrelevant	82.1	17.9

ii) the Psychoanalytic psychotherapy group will contain a higher number of references to emotions than all other therapy groups

iii) the Psychodynamic psychotherapy group will contain a higher number of references to emotions than the Behaviour, Cognitive-behaviour and Cognitive therapy groups

iv) the Cognitive-behaviour grouping of therapies will contain a higher number of references to thoughts than the Psychodynamic grouping

v) the Psychodynamic psychotherapy group will contain a higher number of references to thoughts than the Psychoanalytic psychotherapy group

vi) the Cognitive-behaviour therapy grouping of therapies will contain a higher number of references to observable behaviour such as actions and situations external to the patient than will the Psychodynamic grouping

The rate of therapists' focus on each component of patient functioning was analysed. Mean rates of each of these coding categories across the two therapy groupings is presented in Table 6.2 and across the six therapy groups in Table 6.3.

Table 6.2. The mean rate of therapist references to each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Situation	0.058 (0.051)	0.028 (0.042)
Self Observation	0.026 (0.017)	0.119 (0.157)
Self Evaluation	0.018 (0.016)	0.060 (0.076)
Expectations	0.009 (0.005)	0.045 (0.058)
General Thoughts	0.064 (0.057)	0.127 (0.137)
Intentions	0.013 (0.011)	0.005 (0.009)
Emotions	0.069 (0.029)	0.293 (0.230)
Actions	0.093 (0.049)	0.131 (0.152)

Table 6.3. The mean rate of therapist references to each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Coding Category					
Situation	0.073 (0.091)	0.060 (0.014)	0.042 (0.015)	0.010 (0.021)	0.029 (0.051)	0.044 (0.052)
Self Observation	0.025 (0.021)	0.019 (0.013)	0.033 (0.018)	0.017 (0.003)	0.033 (0.007)	0.308 (0.137)
Self Evaluation	0.003 (0.004)	0.021 (0.007)	0.030 (0.019)	0.015 (0.008)	0.027 (0.005)	0.138 (0.094)
Expectations	0.007 (0.006)	0.009 (0.005)	0.011 (0.004)	0.024 (0.014)	0.017 (0.019)	0.094 (0.082)
General Thoughts	0.076 (0.099)	0.061 (0.033)	0.055 (0.023)	0.058 (0.034)	0.274 (0.122)	0.050 (0.100)
Intentions	0.011 (0.015)	0.013 (0.010)	0.017 (0.013)	0.015 (0.008)	0.000 (0.000)	0.000 (0.000)
Emotions	0.081 (0.033)	0.078 (0.028)	0.049 (0.022)	0.130 (0.072)	0.160 (0.076)	0.588 (0.086)
Actions	0.135 (0.065)	0.076 (0.022)	0.068 (0.022)	0.063 (0.024)	0.022 (0.044)	0.308 (0.137)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' focusing on components of patient functioning across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of therapist focusing than Cognitive-behaviour therapies on emotions ($t(22) = 3.338$, $p<0.005$). The tests also showed Cognitive-behaviour therapies to contain a significantly higher rate of therapist focus on situations than did Psychodynamic psychotherapies ($t(18.463) = 3.194$, $p<0.005$).

The Six Therapy Groups

A series of one-way ANOVAs analysed the occurrence of therapists' focusing on components of patient functioning across the six therapy groups:

A one-way ANOVA for the therapist rate of reference to self observation showed an overall significant effect of type of therapy ($F(5, 18) = 16.295$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$).

A one-way ANOVA for the therapist rate of reference to self evaluation showed an overall significant effect of type of therapy ($F(5, 18) = 6.235$, $p<0.005$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$) therapy group.

A one-way ANOVA for the therapist rate of reference to thoughts showed an overall significant effect of type of therapy ($F(5, 18) = 4.893$, $p<0.005$), with an priori contrast showing more such references were made in the Psychodynamic psychotherapy group than in the Psychoanalytic ($t(18) = 3.994$, $p<0.001$) psychotherapy group.

A one-way ANOVA for the therapist rate of reference to emotions showed an overall significant effect of type of therapy ($F(5, 18) = 47.857$, $p<0.001$). A priori contrasts showed a higher rate of such references in the Psychoanalytic psychotherapy group than in the Behaviour ($t(18) = 12.192$, $p<0.001$), Cognitive-behaviour ($t(18) = 12.273$, $p<0.001$), Cognitive ($t(18) = 12.964$, $p<0.001$), Conversational ($t(18) = 11.030$, $p<0.001$) and Psychodynamic ($t(18) = 10.291$, $p<0.001$) therapy groups. A further series of a priori contrasts showed a higher percentage of statements contained such references in the Psychodynamic psychotherapy group than in the Cognitive therapy group ($t(18) = 2.672$, $p<0.05$). In addition one-way ANOVAs for the percentage of therapist statements focusing on emotions and for the mean coding per therapist statement of

emotions showed overall significant effects of type of therapy ($F(5, 18) = 10.411$, $p<0.001$ and $F(5, 18) = 8.638$, $p<0.001$ respectively). A priori contrasts showed higher percentage codings and higher rate codings of therapist focus on emotions in the Psychodynamic psychotherapy group than in the Behaviour therapy group ($t(18) = 2.263$, $p<0.05$ and $t(18) = 2.149$, $p<0.05$ respectively).

A one-way ANOVA for the therapist rate of reference to actions showed an overall significant effect of type of therapy ($F(5, 18) = 9.583$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Cognitive-behaviour (Scheffe test, $p<0.005$), Cognitive (Scheffe test, $p<0.005$), Conversational (Scheffe test, $p<0.005$) and Psychodynamic (Scheffe test, $p<0.001$).

No other analyses of components of patient functioning showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Components of Patient Functioning

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on emotions than therapists in the Cognitive-behaviour grouping.

Support was obtained for the hypothesis that therapists in the Psychoanalytic psychotherapy group would focus more on emotions than therapists in the other five therapy groups.

Partial support was obtained for the hypothesis that therapists in the Psychodynamic therapy group would focus more on emotions than therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In fact they tended to focus more on emotions than therapists in the Behaviour therapy group and there was some limited evidence they also focused more on emotions than therapists in the Cognitive therapy group.

Support was not obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would focus more on thoughts than therapists in the Psychodynamic grouping.

Support was obtained for the hypothesis than therapists in the Psychodynamic psychotherapy group would focus more on thoughts than therapists in the Psychoanalytic psychotherapy group.

Support was not obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would focus more on actions than therapists in the Psychodynamic grouping.

Support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would focus more on situations than therapists in the Psychodynamic grouping.

Therapists in the Psychodynamic grouping of therapies focused more on expectations than therapists in the Cognitive-behaviour grouping.

Therapists in the Psychoanalytic therapy group focused more on self observation than therapists in the Behaviour, Cognitive-behaviour, Conversational and Psychodynamic therapy group.

There was some evidence that therapists in the Psychoanalytic therapy group focused more on self evaluation than therapists in the Behaviour therapy group.

There was some evidence that therapists in the Psychoanalytic therapy group focused more on actions than therapists in the Cognitive-behaviour, Cognitive, Conversational and Psychodynamic psychotherapy groups.

6.2.2 General Interventions

This section of analyses includes testing of the hypotheses that:

i) therapists in the Cognitive-behaviour grouping of therapies will focus more on giving overt support and reassurance to patients than therapists in the Psychodynamic grouping

ii) therapists in the Cognitive-behaviour grouping of therapies will self disclose more than those in the Psychodynamic grouping

iii) therapists in Cognitive-behaviour grouping of therapies will focus more on giving general information that has therapeutic implications to patients than will therapists in the Psychodynamic grouping

iv) therapists in the Psychodynamic grouping of therapies will focus more than those in the Cognitive-behaviour grouping on patients' avoidance of thoughts, feelings and behaviours which are pertinent to the therapeutic process

The rate of therapists' focus on each category of general interventions was analysed. Mean rates for each of these coding categories are presented for the two therapy groupings, Cognitive-behaviour and Psychodynamic in Table 6.4 and for the six therapy groups in Table 6.5.

Table 6.4. The mean rate of therapist references to each coding category of General Interventions of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Reality/Unreality	0.035 (0.032)	0.089 (0.087)
Reaction of Another	0.018 (0.017)	0.104 (0.161)
Significant Theme	0.005 (0.007)	0.009 (0.011)
Therapist Support	0.011 (0.009)	0.002 (0.005)
Information Giving	0.005 (0.006)	0.001 (0.001)
Changes	0.008 (0.007)	0.004 (0.010)
Avoidance	0.003 (0.006)	0.089 (0.144)
Self Disclosure	0.010 (0.017)	0.001 (0.003)

Table 6.5. The mean rate of therapist references to each coding category of General Interventions of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Reality/Unreality	0.007 (0.011)	0.038 (0.032)	0.060 (0.026)	0.047 (0.028)	0.020 (0.010)	0.200 (0.039)
Reaction of Another	0.009 (0.008)	0.015 (0.012)	0.031 (0.022)	0.029 (0.018)	0.090 (0.024)	0.194 (0.274)
Significant Theme	0.000 (0.000)	0.010 (0.010)	0.004 (0.004)	0.016 (0.013)	0.012 (0.009)	0.000 (0.000)
Therapist Support	0.017 (0.007)	0.005 (0.007)	0.010 (0.010)	0.006 (0.009)	0.000 (0.000)	0.000 (0.000)
Information Giving	0.008 (0.008)	0.004 (0.006)	0.003 (0.001)	0.001 (0.001)	0.000 (0.000)	0.000 (0.000)
Changes	0.009 (0.011)	0.006 (0.005)	0.009 (0.004)	0.005 (0.006)	0.008 (0.016)	0.000 (0.000)
Avoidance	0.000 (0.000)	0.005 (0.010)	0.003 (0.004)	0.027 (0.018)	0.026 (0.016)	0.214 (0.211)
Self Disclosure	0.023 (0.027)	0.004 (0.004)	0.002 (0.002)	0.004 (0.003)	0.000 (0.000)	0.000 (0.000)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' focusing on general interventions across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of therapist focusing than Cognitive-behaviour therapies on avoidance ($t(22) = 2.070$, $p<0.05$). The tests also showed Cognitive-behaviour therapies to contain a significantly higher rate than Psychodynamic psychotherapies of therapists' giving support ($t(22) = 2.939$, $p<0.01$) and information ($t(22) = 2.822$, $p<0.01$). In addition, independent samples t-Tests also showed a higher mean total of references per statement to self disclosure in the Cognitive-behaviour grouping and this approached significance ($t(13.465) = 2.011$, $p<0.57$).

The Six Therapy Groups

A one-way ANOVA for the therapist rate of reference to reality-unreality showed an overall significant effect of type of therapy ($F(5, 18) = 28.320$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$).

A one-way ANOVA for the rate of therapist support showed an overall significant effect of type of therapy ($F(5, 18) = 3.633$, $p<0.05$). Further analyses though did not find significant differences between any two of the six therapy groups.

A one-way ANOVA for the rate of therapist focus on avoidance showed an overall significant effect of type of therapy ($F(5, 18) = 3.675$, $p<0.05$). Further analyses though did not find significant differences between any two of the six therapy groups.

No other analyses of general interventions showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

General Interventions

Support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would focus more on giving support and reassurance than therapists in the Psychodynamic grouping.

Support was obtained for the hypotheses that therapists in the Cognitive-behaviour grouping of therapies would focus more on giving information than therapists in the Psychodynamic grouping.

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on avoidance than therapists in the Cognitive-behaviour grouping.

Some support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would self-disclose more than therapists in the Psychodynamic grouping.

Therapists in the Psychoanalytic psychotherapy group focused more on reality-unreality than therapists in the Behaviour therapy group. There was also some evidence they focused more on reality-unreality than therapists in the other four therapy groups.

6.2.3 Intrapersonal Links

The rate of therapists' focus on each category of intrapersonal links was analysed. Mean rates for each of these coding categories are presented for the two therapy groupings, Cognitive-behaviour and Psychodynamic in Table 6.6 and for the six therapy groups in Table 6.7.

Table 6.6. The mean rate of therapist references to each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Similarity/Patterns	0.012 (0.010)	0.053 (0.080)
Difference/Incongruity	0.006 (0.008)	0.008 (0.011)
Vicious Circle	0.001 (0.002)	0.000 (0.000)
Consequences	0.020 (0.015)	0.144 (0.170)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' focusing on intrapersonal links across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed a higher rate of therapist focus on intrapersonal consequences in the Psychodynamic psychotherapies than in the Cognitive-behaviour therapies ($t(22) = 2.820$, $p<0.01$).

Table 6.7. The mean rate of therapist references to each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Similarity/Patterns	0.006	0.021	0.009	0.005	0.016	0.138
	(0.006)	(0.010)	(0.006)	(0.006)	(0.005)	(0.094)
Difference/Incongruity	0.001	0.011	0.005	0.007	0.018	0.000
	(0.001)	(0.013)	(0.003)	(0.008)	(0.012)	(0.000)
Vicious Cycle	0.000	0.001	0.001	0.000	0.000	0.000
	(0.000)	(0.002)	(0.002)	(0.000)	(0.000)	(0.000)
Consequences	0.009	0.035	0.018	0.030	0.045	0.358
	(0.010)	(0.015)	(0.006)	(0.023)	(0.009)	(0.120)

The Six Therapy Groups

A one-way ANOVA for the rate of therapist focus on similarities/patterns showed an overall significant effect of type of therapy ($F(5, 18) = 7.105$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.01$), Cognitive (Scheffe test, $p<0.01$) and Conversational (Scheffe test, $p<0.01$) therapy groups.

A one-way ANOVA for the rate of therapist focus on consequences showed an overall significant effect of type of therapy ($F(5, 18) = 28.918$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe test, $p<0.001$), Cognitive-behaviour (Scheffe test, $p<0.001$), Cognitive (Scheffe test, $p<0.001$), Conversational (Scheffe test, $p<0.001$) and Psychodynamic (Scheffe test, $p<0.001$) therapy groups.

No other analyses of intrapersonal links showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Intrapersonal links

Therapists in the Psychodynamic grouping of therapies focused more on intrapersonal consequences than therapists in the Cognitive-behaviour grouping.

Therapists in the Psychoanalytic therapy group focused more on intrapersonal consequences than therapists in the Behaviour and Cognitive therapy groups. There was also some evidence they focused more on intrapersonal consequences than therapists in the Cognitive-behaviour, Conversational and Psychodynamic therapy groups.

Therapists in the Psychoanalytic therapy group focused more on intrapersonal similarities/patterns than therapists in the Behaviour, Cognitive and Conversational therapy groups.

6.2.4 Interpersonal Links

This section of analyses includes testing of the hypotheses that:

i) therapists in the Psychodynamic grouping of therapies will make a higher number of references to patients' patterns of interpersonal relating than will therapists in the Cognitive-behaviour grouping of therapies

ii) therapists in the Psychodynamic grouping of therapies will make a higher number of references drawing patients' attention to their impact on others

iii) therapists in the Cognitive-behaviour grouping of therapies will make a higher number of references drawing patients' attention to others impact on them

The rate of therapists' focus on each category of intrapersonal links was analysed. Mean rates of each of these coding categories are presented for the two therapy groupings in Table 6.8 and for the six therapy groups in Table 6.9.

Table 6.8. The mean rate of therapist references to each coding category of Interpersonal Links of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patterns	0.005 (0.008)	0.024 (0.033)
Vicious Cycle	0.000 (0.000)	0.000 (0.000)
Consequences	0.009 (0.008)	0.046 (0.064)
Direction of consequences:		
patient to other	0.001 (0.001)	0.018 (0.034)
other to patient	0.008 (0.008)	0.027 (0.034)
Compares/Contrasts	0.007 (0.007)	0.002 (0.005)
General Interaction	0.010 (0.013)	0.014 (0.018)

Table 6.9. The mean rate of therapist references to each coding category of Interpersonal Links of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Patterns	0.001	0.011	0.002	0.014	0.014	0.044
	(0.002)	(0.010)	(0.004)	(0.020)	(0.014)	(0.052)
Vicious Cycle	0.000	0.000	0.000	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Consequences	0.010	0.012	0.004	0.018	0.033	0.088
	(0.011)	(0.005)	(0.004)	(0.008)	(0.023)	(0.103)
Dir.of Consequences:						
patient to other	0.000	0.001	0.001	0.005	0.005	0.044
	(0.000)	(0.002)	(0.001)	(0.008)	(0.011)	(0.052)
other to patient	0.010	0.011	0.004	0.001	0.027	0.044
	(0.011)	(0.006)	(0.005)	(0.010)	(0.026)	(0.052)
Compares/Contrasts	0.005	0.010	0.006	0.004	0.003	0.000
	(0.004)	(0.012)	(0.004)	(0.006)	(0.005)	(0.000)
General Interaction	0.014	0.013	0.003	0.034	0.009	0.000
	(0.022)	(0.007)	(0.003)	(0.019)	(0.006)	(0.000)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapist focus on interpersonal links across the two groupings of therapies, Cognitive-behaviour and Psychodynamic. These analyses did not find a significant effect of therapy grouping on the rate of therapists' focus on any category of interpersonal link. However, independent samples t-Tests did show the Psychodynamic grouping of therapies to contain a higher percentage of therapists' statements focusing on interpersonal patterns and a higher mean occurrence of therapist focus on interpersonal patterns than did the Cognitive-behaviour grouping of therapies ($t(22) = 2.156$, $p<0.05$ and $t(22) = 2.277$, $p<0.05$ respectively). In addition, independent samples t-Tests also showed the Psychodynamic grouping to contain percentage of therapist statements focusing on the patient's impact on others ($t(22) = 1.927$, $p<0.05$).

The Six Therapy Groups

A one-way ANOVA for the rate of therapist focus on interpersonal general interactions showed an overall significant effect of type of therapy ($F(5, 18) = 8.751$, $p<0.001$). Further analyses showed more such references were made in the Conversational psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Psychodynamic and Psychoanalytic therapy groups (Scheffe tests, $p<0.005$, $p<0.005$, $p<0.005$, $p<0.005$ and $p<0.005$ respectively).

No other analyses of intrapersonal links showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Interpersonal links

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on interpersonal patterns than therapists in the Cognitive-behaviour grouping.

Some support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would make a higher number of references drawing patients' attention to their impact on others than would therapists in the Cognitive-behaviour grouping.

Support was not obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would make a higher number of references drawing patients' attention to others impact

on them than would therapists in the Psychodynamic grouping. In fact references to this were higher in the Psychodynamic group but did not reach significance.

Therapists in the Conversational therapy group focused more on interpersonal general interactions than therapists in the other five groups.

6.2.5 The Total of Interpersonal and Intrapersonal References and the Ratio of Interpersonal to Intrapersonal References

This section of analyses includes testing of the hypotheses that:

i) therapists in the Psychodynamic grouping of therapies will make a higher number of interpersonal references that therapists in the Cognitive-behaviour grouping

ii) the number of references to intrapersonal references across the Psychodynamic grouping of therapies and the Cognitive-behaviour grouping of therapies will not be significantly different

The total rate of therapists' focus on intrapersonal links and on interpersonal links was analysed. The total rates of these intrapersonal and interpersonal links divided by the respective numbers of different coding categories subsumed within each was also calculated. So too was the ratio of intrapersonal to interpersonal references in groups. These mean total rates and ratios are presented for the two therapy groupings in Table 6.10 and for the six therapy groups in Table 6.11.

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' focusing on summated intrapersonal links and summated interpersonal links across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The tests also compared the mean summated rates of intrapersonal factors divided by the number of intrapersonal coding categories (4) and the mean summated rates of interpersonal factors divided by the number of interpersonal coding categories (5). These tests showed therapists' statements within Psychodynamic psychotherapies to contain a significantly higher rate than did Cognitive-behaviour therapies of all four variables: of summated intrapersonal codings ($t(22) = 2.876$, $p<0.01$), summated intrapersonal codings divided by the number of factors ($t(22) = 2.876$, $p<0.01$), summated intrapersonal codings ($t(22) = 2.294$, $p<0.01$) and summated interpersonal codings divide by the number of factors ($t(22) = 2.294$, $p<0.05$). Both groups contained a higher mean total of references to intrapersonal factors as compared with interpersonal factors.

Table 6.10. Mean Rate of Therapist Focus on Summated Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus and the Ratio of these factors within groups (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Intrapersonal Total	0.039 (0.030)	0.210 (0.203)
Intrapersonal Total/ no of Factors	0.010 (0.008)	0.052 (0.051)
Interpersonal Total	0.031 (0.022)	0.088 (0.084)
Interpersonal Total/ no of Factors	0.006 (0.004)	0.018 (0.017)
Ratio of Intrapersonal to Interpersonal Factors	1.26 : 1	2.39 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	1.67 : 1	2.89 : 1

Table 6.11. Mean Rate of Therapist Focus on Summated Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus and the Ratio of these factors within groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Intrapersonal Total	0.016 (0.013)	0.069 (0.032)	0.032 (0.015)	0.072 (0.045)	0.108 (0.056)	0.449 (0.175)
Intrapersonal Total/ no of Factors	0.004 (0.003)	0.017 (0.008)	0.008 (0.009)	0.018 (0.011)	0.027 (0.014)	0.112 (0.044)
Interpersonal Total	0.030 (0.028)	0.046 (0.019)	0.016 (0.005)	0.080 (0.021)	0.087 (0.076)	0.099 (0.140)
Interpersonal Total/ no of Factors	0.006 (0.006)	0.009 (0.004)	0.003 (0.001)	0.016 (0.004)	0.017 (0.015)	0.020 (0.028)
Ratio of Intrapersonal to Interpersonal Factors	0.53 : 1	1.50 : 1	2.00 : 1	0.90 : 1	1.24 : 1	4.54 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	0.67 : 1	1.89 : 1	2.67 : 1	1.13 : 1	1.59 : 1	5.60 : 1

The Six Therapy Groups

A one-way ANOVA for the rate of therapists' focusing on summated intrapersonal links showed an overall significant effect of type of therapy ($F(5, 18) = 16.930$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic groups (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.001$) therapy groups.

No other analyses of summated intrapersonal and summated interpersonal links showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Total intrapersonal and interpersonal references and the ratio of intrapersonal to interpersonal references

Support was obtained for the hypothesis that the Psychodynamic grouping of therapies would have a higher total of interpersonal references in therapist statements than the Cognitive-behaviour grouping.

Support was not obtained for the hypothesis that there would not be any significant difference between the Psychodynamic and the Cognitive-behaviour grouping of therapies with respect to the total number of intrapersonal references in therapist statements. The Psychodynamic grouping had a higher total than the Cognitive-behaviour grouping.

Both the Cognitive-behaviour and the Psychodynamic grouping of therapies had a higher total of intrapersonal references in therapist statements than of interpersonal references.

The Psychoanalytic psychotherapy group had a higher total of intrapersonal references in therapist statements than the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic therapy groups.

6.2.6 Who Therapists Focus On

This section of analyses includes testing of the hypotheses that:

i) therapists in the Psychodynamic grouping of therapies will make a higher number of references to themselves than therapists in the Cognitive-behaviour grouping of therapies.

ii) therapists in the Psychodynamic grouping of therapies will make a higher number of references to parents than therapists in the Cognitive-behaviour grouping of therapies.

iii) therapists in the Psychodynamic psychotherapy group will make a higher number of references to parents than therapists in the other five therapy groups.

iv) therapists in the Psychodynamic grouping of therapies will make a higher number of references to dream or fantasy figures than therapists in the Cognitive-behaviour grouping of therapies.

v) therapists in the Psychoanalytic psychotherapy group will make a higher number of references to dream or fantasy figures than therapists in the other five therapy groups.

The rate of therapists' focus on each person category was analysed. The mean rate of each of these coding categories is presented for the two therapy groupings, Cognitive-behaviour and Psychodynamic, in Table 6.12 and for the six therapy groups in Table 6.13.

Table 6.12. The mean rate of therapist focus on each coding category of Persons Involved of the Coding System of Therapeutic Focus statements across the two therapy groupings (standard deviation in brackets)

Group Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Patient	0.338 (0.107)	0.485 (0.175)
Therapist	0.041 (0.034)	0.096 (0.098)
Parent	0.006 (0.007)	0.129 (0.118)
Mate	0.024 (0.036)	0.103 (0.177)
Child	0.015 (0.029)	0.019 (0.035)
Dream/Fantasy Figure	0.000 (0.000)	0.008 (0.015)
Acquaintance/Strangers and Others in General	0.069 (0.048)	0.051 (0.059)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' focusing on each person category across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of therapist focusing than Cognitive-behaviour therapies on the therapist ($t(22) = 2.193$, $p<0.05$) and on parents ($t(22) = 3.613$, $p<0.005$).

Table 6.13. The mean rate of therapist focus on each coding category of Persons Involved of the Coding System of Therapeutic Focus statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Patient	0.413	0.340	0.262	0.354	0.425	0.676
	(0.079)	(0.124)	(0.072)	(0.079)	(0.027)	(0.170)
Therapist	0.083	0.022	0.017	0.067	0.038	0.182
	(0.023)	(0.010)	(0.007)	(0.049)	(0.032)	(0.128)
Parent	0.009	0.003	0.005	0.022	0.159	0.206
	(0.008)	(0.006)	(0.005)	(0.027)	(0.059)	(0.150)
Mate	0.014	0.055	0.002	0.008	0.014	0.286
	(0.025)	(0.047)	(0.004)	(0.007)	(0.027)	(0.218)
Child	0.001	0.037	0.006	0.057	0.000	0.000
	(0.002)	(0.044)	(0.010)	(0.039)	(0.000)	(0.000)
Dream/ Fantasy Figure	0.000	0.000	0.000	0.000	0.000	0.031
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.029)
Acquaintance, Stranger	0.106	0.039	0.062	0.060	0.093	0.000
Others in General	(0.047)	(0.029)	(0.049)	(0.033)	(0.076)	(0.000)

The Six Therapy Groups

A one-way ANOVA for the rate of therapist focus on the patient showed an overall significant effect of type of therapy ($F(5, 18) = 7.763$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Cognitive-behaviour (Scheffe test, $p<0.01$) and Cognitive (Scheffe test, $p<0.001$) therapy groups. A one-way ANOVA for the mean coding of such references also showed an overall significant effect of type of therapy ($F(5, 18) = 5.832$, $p<0.01$), with further analyses showing the mean of these references was higher in the Conversational psychotherapy group than in the Behaviour therapy group (Scheffe test, $p<0.01$).

A one-way ANOVA for the rate of therapist focus on parents showed an overall significant effect of type of therapy ($F(5, 18) = 4.441$, $p<0.01$). A priori contrasts showed a higher rate of such references in the Psychodynamic psychotherapy group than in the Behaviour ($t(18) = 3.164$, $p<0.005$), Cognitive-behaviour ($t(18) = 3.296$, $p<0.005$), Cognitive ($t(18) = 3.264$, $p<0.005$) and Conversational ($t(18) = 2.898$, $p<0.01$) therapy groups.

A one-way ANOVA for the rate of therapist focus on a dream or fantasy figure showed an overall significant effect of type of therapy ($F(5, 18) = 6.540$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour,

Cognitive-behaviour, Cognitive, Conversational and Psychodynamic (Scheffe tests, $p<0.05$, $p<0.05$, $p<0.05$, $p<0.05$, $p<0.05$ respectively) therapy groups.

One-way ANOVAs for the rate of therapist focus on the therapist and on a mate both showed overall significant effects of type of therapy ($F(5, 18) = 4.441$, $p<0.01$ and $F(5, 18) = 5.769$, $p<0.01$). However, further analyses did not show a significant difference between any two of the six therapy groups on either person category.

No other analyses of who therapists focus on showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Who therapists focus on

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on themselves than therapists in the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on parents than therapists in the Cognitive-behaviour grouping of therapies.

Partial support was obtained for the hypothesis that therapists in the Psychodynamic psychotherapy group would focus more on parents than therapists in all five other therapy groups. In fact therapists in the Psychodynamic psychotherapy group focused more on parents than therapists in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. They did also focus more on parents than did therapists in the Psychoanalytic psychotherapy group but this was not statistically significant.

Support was obtained for the hypothesis that therapists in the Psychoanalytic psychotherapy group would focus more on dream and fantasy figures than therapists in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. They also focused on dream and fantasy figures more than therapists in the Psychodynamic psychotherapy group.

Support was not obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on dream and fantasy figures than therapists in the Cognitive-behaviour grouping of therapies.

6.2.7 The Time Frame of Therapists' Interventions

This section of analyses includes testing of the hypotheses that:

i) therapists in the Psychodynamic grouping of therapies will focus on the pre-adult past time frame more than therapists in the Cognitive-behaviour grouping of therapies

ii) therapists in the Psychodynamic psychotherapy group will focus on the pre-adult past time frame more than therapists in the other five therapy groups.

iii) there will be no significant different across the Psychodynamic and Cognitive-behaviour grouping of therapies in the amount therapists focus on a current time frame.

iv) there will be no significant different across the six therapy groups in the amount therapists focus on a current time frame.

v) therapists in the Psychodynamic grouping of therapies will work more in an in-session time frame than therapists in the Cognitive-behaviour grouping of therapies.

vi) therapists in the Psychoanalytic psychotherapy group will work more in an in-session time frame than therapists in the other five therapy groups.

vii) therapists in the Psychodynamic psychotherapy group will work more in an in-session time frame than therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

viii) therapists in the Cognitive-behaviour grouping of therapies will focus more in a future time frame than therapists in the Psychodynamic grouping of therapies

The rate of therapists' focus on each time frame category was analysed. Mean ratings of each of these categories is presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table 6.14 and for the six therapy groups in Table 6.15.

Table 6.14. The rate of therapist focus on each coding category of Time Frame of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Pre-Adult Past	0.003 (0.007)	0.058 (0.102)
Adult Past	0.040 (0.090)	0.111 (0.168)
Current	0.124 (0.053)	0.182 (0.144)
In Session	0.041 (0.034)	0.227 (0.226)
Future	0.073 (0.046)	0.027 (0.046)
General	0.110 (0.072)	0.136 (0.130)
Irrelevant/Unspecified	0.115 (0.138)	0.019 (0.022)

Table 6.15. The rate of therapist focus on each coding category of Time Frame of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Pre-Adult Past	0.004	0.000	0.005	0.015	0.114	0.044
	(0.007)	(0.000)	(0.010)	(0.029)	(0.166)	(0.052)
Adult Past	0.096	0.011	0.013	0.027	0.082	0.224
	(0.151)	(0.010)	(0.013)	(0.022)	(0.077)	(0.263)
Current	0.135	0.108	0.131	0.144	0.065	0.336
	(0.073)	(0.038)	(0.055)	(0.038)	(0.059)	(0.139)
In Session	0.078	0.003	0.039	0.067	0.126	0.488
	(0.025)	(0.007)	(0.015)	(0.035)	(0.064)	(0.210)
Future	0.097	0.079	0.044	0.062	0.021	0.000
	(0.069)	(0.019)	(0.025)	(0.070)	(0.014)	(0.000)
General	0.074	0.170	0.086	0.123	0.185	0.100
	(0.058)	(0.078)	(0.046)	(0.054)	(0.119)	(0.200)
Irrelevant/Unspecified	0.272	0.019	0.053	0.020	0.035	0.000
	(0.140)	(0.014)	(0.007)	(0.021)	(0.023)	(0.000)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' focusing on each time frame across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of therapist focusing than Cognitive-behaviour therapies on in-session ($t(22) = 2.809$, $p<0.01$) and pre-adult past ($t(22) = 1.854$, $p<0.05$) time frames. They also showed the Cognitive-behaviour therapies to contain a significantly higher rate of therapist focusing than the Psychodynamic on future ($t(22) = 2.448$, $p<0.05$) and irrelevant or unspecified ($t(22) = 2.373$, $p<0.05$) time frames.

The Six Therapy Groups

A one-way ANOVA for the rate of therapist focus on the current time frame showed an overall significant effect of type of therapy ($F(5, 18) = 6.262$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Psychodynamic (Scheffe test, $p<0.01$).

A one-way ANOVA for the rate of therapist focus on an in-session time frame showed an overall significant effect of type of therapy ($F(5, 18) = 6.262$, $p<0.001$). A priori contrasts showed a higher rate of such references were made in the Psychoanalytic psychotherapy group than in the Behaviour ($t(18) = 6.329$, $p<0.001$), Cognitive-behaviour ($t(18) = 7.418$, $p<0.001$), Cognitive ($t(18) = 6.931$, $p<0.001$), Conversational ($t(18) = 6.500$, $p<0.001$) and Psychodynamic ($t(18) = 5.580$, $p<0.001$) therapy groups. Further one-way ANOVAs also showed an overall significant effect of type of therapy on the percentage of therapist statements focusing on an in session time frame and on the mean coding of this time frame ($F(5, 18) = 11.505$, $p<0.001$ and $F(5, 18) = 11.560$, $p<0.001$ respectively). A priori contrasts showed a higher percentage of statements containing in-session codings in the Psychodynamic psychotherapy group than in the Behaviour and Cognitive-behaviour therapy groups ($t(18) = 2.122$, $p<0.05$ and $t(18) = 3.180$, $p<0.005$ respectively). They also showed a higher mean coding of the in-session time frame in Psychodynamic psychotherapy group than in the Cognitive-behaviour therapy group ($t(18) = 2.561$, $p<0.05$).

A one-way ANOVA for the rate of therapist focus on the future time frame showed an overall significant effect of type of therapy ($F(5, 18) = 2.909$, $p<0.05$). However, further analyses showed no significant difference between any two groups.

A one-way ANOVA for the rate of therapist focus on an irrelevant or unspecified time frame also showed an overall significant effect of type of therapy ($F(5, 18) = 12.025$, $p<0.001$). Further analyses showed more such references were made in the Behaviour therapy group than in the

Cognitive-behaviour, Cognitive, Conversational, Psychodynamic and Psychoanalytic (Scheffe tests, $p<0.001$, $p<0.005$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.001$ respectively) therapy groups.

No other analyses of the time frames therapists focused on showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Time frames

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on the pre-adult past time frame than therapists in the Cognitive-behaviour grouping.

Support was not obtained for the hypothesis that therapists in the Psychodynamic psychotherapy group would focus more on childhood than therapists in the other five therapy groups. Although they focused more on all measures this was not significant.

Support was obtained for the hypothesis that there would be no difference between therapists in the Psychodynamic and in the Cognitive-behaviour grouping of therapies in the amount they would focus on a current time frame.

Unequivocal support was not obtained for the hypothesis that there would be no difference between therapists in the six therapy groups in the amount they would focus on a current time frame. On two measures there was, as hypothesised, no significant difference but on a third, rate, the Psychoanalytic psychotherapy group scored higher than the Psychodynamic psychotherapy group.

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would focus more on an in-session time frame than therapists in the Cognitive-behaviour grouping.

Support was obtained for the hypothesis that therapists in the Psychoanalytic psychotherapy group would focus more on an in-session time frame than therapists in the other five therapy groups.

Partial support was obtained for the hypothesis that therapists in the Psychodynamic psychotherapy group would focus more on an in-session time frame than therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In fact they focused more on an in-session time frame than did therapists in the Behaviour and Cognitive-behaviour therapy groups.

Support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would focus more on a future time frame than would therapists in the Psychodynamic grouping.

Therapists in the Cognitive-behaviour grouping of therapies focused more on an irrelevant/ unspecified time frame than therapists in the Psychodynamic grouping.

Therapists in the Behaviour therapy group focused more on an irrelevant/ unspecified time frame than did therapists in the other five therapy groups.

6.2.8 Person Links and Time Links

This section of analyses includes testing of the hypotheses that:

i) therapists in the Psychodynamic grouping of therapies will make a greater number of links between person categories than will therapists in the Cognitive-behaviour grouping of therapies

ii) therapists in the Psychodynamic grouping of therapies will make a greater number of links between time frame categories than will therapists in the Cognitive-behaviour grouping of therapies

The rate of therapists' linking of time frames and linking of person categories was analysed. Mean rates of these time links and person links are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table 6.16 and for the six therapy groups in Table 6.17.

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the rate of therapists' linking of time frames and of person categories across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. These tests showed Psychodynamic therapies to contain a significantly higher rate of therapist focusing than Cognitive-behaviour therapies on linking of time frames ($t(22) = 2.829$, $p<0.01$) and of persons categories ($t(22) = 2.370$, $p<0.05$).

Table 6.16. The Rate of Time Links and Person Links of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Time Links	0.006 (0.007)	0.162 (0.192)
Person Links	0.003 (0.004)	0.084 (0.118)

Table 6.17. The Rate of Time Links and Person Links of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Time Links	0.007 (0.009)	0.001 (0.002)	0.008 (0.007)	0.043 (0.042)	0.065 (0.051)	0.380 (0.189)
Person Links	0.001 (0.001)	0.002 (0.004)	0.007 (0.005)	0.015 (0.008)	0.051 (0.042)	0.188 (0.165)

The Six Therapy Groups

A one-way ANOVA for the rate of therapists making links between time frames also showed an overall significant effect of type of therapy ($F(5, 18) = 12.887$, $p<0.001$). Further analyses showed more such references were made in the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychodynamic (Scheffe tests, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$ and $p<0.005$ respectively) therapy groups.

A one-way ANOVA showed an overall significant effect of type of therapy for the rate of therapists' making person links ($F(5, 18) = 4.405$, $p<0.01$). However, further analyses did not show a significant difference between any two of the six therapy groups.

No other analyses of the linking of time frames or of person categories showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Person links and Time links

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would make a greater number of links between person categories than would therapists in the Cognitive-behaviour grouping.

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would make a greater number of links between time frames than would therapists in the Cognitive-behaviour grouping.

Therapists in the Psychoanalytic psychotherapy group made a greater number of links between time frames than did therapists in the Behaviour, Cognitive-behaviour, Cognitive and Conversational therapy groups. There was also some evidence that they made a greater number of links between time frames than therapists in the Psychodynamic psychotherapy group.

6.3 Comparison of Coding Categories across Early and Late Sessions and by Type of Therapy

Therapists' foci on the various coding categories of the Coding System of Therapeutic Focus were analysed across early and late sessions and type of therapy grouping. As in the preceding section only the results of analyses of measures of rates are presented in the main text, unless there were significant differences between these and analyses of percentages and means. In addition, the main text also only presents the results of analyses across the two therapy groupings, not of those across the six therapy groups. This is because the limited numbers in each of the 12 conditions of the two-way analysis of variance across six therapy groups limit the detection of experimental effects and their generalisability. Analyses of percentages and means and analyses across the six therapy groups are reported in Appendix 9.

6.3.1 Components of Patient Functioning

The rate of therapists' focus on each component of patient functioning was analysed across early and late sessions and the two therapy groupings. Mean ratings of each of these categories is presented in Table 6.18.

Table 6.18. The mean rate of therapist references to each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Situation (E)	0.038 (0.027)	0.041 (0.050)
(L)	0.079 (0.062)	0.015 (0.031)
Self Observation (E)	0.029 (0.021)	0.151 (0.204)
(L)	0.022 (0.013)	0.087 (0.100)
Self Evaluation (E)	0.021 (0.016)	0.048 (0.075)
(L)	0.015 (0.016)	0.071 (0.083)
Expectations (E)	0.010 (0.005)	0.026 (0.038)
(L)	0.008 (0.005)	0.064 (0.070)
General Thoughts (E)	0.092 (0.068)	0.140 (0.176)
(L)	0.037 (0.024)	0.115 (0.100)
Intentions (E)	0.009 (0.010)	0.005 (0.008)
(L)	0.018 (0.013)	0.005 (0.010)
Emotions (E)	0.075 (0.027)	0.281 (0.262)
(L)	0.064 (0.033)	0.304 (0.217)
Actions (E)	0.079 (0.055)	0.174 (0.190)
(L)	0.107 (0.042)	0.088 (0.102)

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of therapists' focusing on components of patient functioning across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The analysis showed no significant effect of session order or of the interaction of session order and type of therapy on references to any component of patient functioning. There were however significant effects of type of therapy on measures of rate of components of patient functioning which replicated the findings from independent samples t-Tests reported above (see page 232).

The rate of therapist focus on thoughts was lower in late sessions of the Cognitive-behaviour grouping of therapies than in early sessions, but this was not significant ($t(5) = 2.591$, $p<0.05$).

No other analyses of therapist focus on components of patient functioning showed a significant effect of the interaction of session order and therapy grouping.

Summary

Components of patient functioning across early and late sessions

There was some suggestion, though not statistically significant, that therapist focus on thoughts decreased in late over early sessions of the Cognitive-behaviour grouping of therapies.

6.3.2. General Interventions

This section of analyses includes testing of the hypotheses that:

i) therapist giving of support would reduce in late over early sessions of the Psychodynamic grouping of therapies and increase in the Cognitive-behaviour grouping

ii) therapist giving of information would reduce in late over early sessions of the Psychodynamic grouping of therapies

The rate of therapists' focus on each component of general interventions was analysed across early and late sessions and the two therapy groupings. Mean ratings of each of these categories is presented in Table 6.19.

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of therapists' focusing on general interventions across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The analysis showed a significant effect of the interaction of session order and type of therapy on therapist provision of support ($F(1, 10) = 10.009$, $p<0.01$) with the Cognitive-behaviour grouping having a higher level of supportive interventions which significantly increased ($t(5) = 3.087$, $p<0.05$) in late over early sessions whereas in the Psychodynamic psychotherapies group they reduced.

There were significant effects of type of therapy on measures of rate of general interventions which replicated the findings from independent samples t-Tests reported above (see page 236).

No other analyses of therapist focus on components of general interventions showed a significant effect of the interaction of session order and therapy grouping.

Table 6.19. The mean rate of therapist references to each coding category of General Interventions of the Coding System of Therapeutic Focus across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Reality/Unreality (E)	0.295 (0.032)	0.098 (0.100)
(L)	0.040 (0.033)	0.080 (0.080)
Reaction of Another (E)	0.020 (0.016)	0.061 (0.041)
(L)	0.017 (0.019)	0.148 (0.225)
Significant Theme (E)	0.007 (0.009)	0.008 (0.013)
(L)	0.002 (0.003)	0.010 (0.009)
Therapist Support (E)	0.005 (0.005)	0.003 (0.007)
(L)	0.016 (0.009)	0.001 (0.002)
Information Giving (E)	0.003 (0.002)	0.001 (0.001)
(L)	0.008 (0.008)	0.000 (0.000)
Changes (E)	0.007 (0.006)	0.002 (0.004)
(L)	0.009 (0.008)	0.007 (0.013)
Avoidance (E)	0.004 (0.008)	0.130 (0.197)
(L)	0.001 (0.003)	0.048 (0.055)
Self Disclosure (E)	0.012 (0.025)	0.002 (0.003)
(L)	0.007 (0.006)	0.001 (0.002)

Summary

General interventions across early and late sessions

Support was obtained for the hypothesis that therapist giving of support would increase in late over early sessions of the Cognitive-behaviour grouping of therapies.

Support was not obtained for the hypothesis that therapist giving of support would decrease in late over early sessions of the Psychodynamic grouping of therapies. Two measures of the occurrence of support (mean and rate) showed small decreases in late over early sessions and one (percentage) a small increase, none being significant. These all reflected therapist activity in the Conversational psychotherapy group; the Psychoanalytic and Psychodynamic groups did not contain any coded therapist offering of support.

Therapist giving of support was a little higher in early sessions of the Cognitive-behaviour grouping of therapies than in early sessions of the Psychodynamic grouping of therapies. This giving of support then increased in late over early sessions of the Cognitive-behaviour grouping

and tended to decrease in the Psychodynamic grouping. As a result later sessions found the Cognitive-behaviour grouping to have a much higher level of giving support than the Psychodynamic grouping.

Support was not obtained for the hypothesis that therapist giving of information would reduce in late over early sessions of the Psychodynamic grouping of therapies. There was however a non-significant reduction which reflected activity in the Conversational group; the Psychoanalytic and Psychodynamic groups did not contain any coded therapist giving of information.

6.3.3. Intrapersonal Links

The rate of therapists' focus on each category of intrapersonal links was analysed across early and late sessions and the two therapy grouping. Mean ratings of each of these categories is presented in Table 6.20.

Table 6.20. The mean rate of therapist references to each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Similarity/Patterns (E)	0.016 (0.009)	0.038 (0.079)
(L)	0.008 (0.009)	0.068 (0.086)
Difference/Incongruity (E)	0.009 (0.011)	0.007 (0.011)
(L)	0.003 (0.003)	0.009 (0.011)
Vicious Circle (E)	0.001 (0.001)	0.000 (0.000)
(L)	0.001 (0.002)	0.000 (0.000)
Consequences (E)	0.025 (0.018)	0.157 (0.200)
(L)	0.016 (0.010)	0.132 (0.153)

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of therapists' focusing on intrapersonal links across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The analysis showed no significant effect of session order or of the interaction of session order and therapy type. There was a significant effect of type of therapy on the rate of intrapersonal consequences which replicated the finding from an independent sample t-Test reported above (see page 237).

No other analyses of therapist focus on intrapersonal links showed a significant effect of the interaction of session order and therapy grouping.

Summary

Intrapersonal links across early and late sessions

There was no significant effect of session order or the interaction of session order and therapy grouping on any category of intrapersonal links

6.3.4 Interpersonal Links

The rate of therapists' focus on each category of interpersonal links was analysed across early and late sessions and the two therapy groupings. Mean rates of each of these categories is presented in Table 6.21.

Table 6.21. The mean rate of therapist references to each coding category of Interpersonal Links of the Coding System of Therapeutic Focus across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group / Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Patterns (E)	0.006 (0.007)	0.026 (0.040)
(L)	0.004 (0.009)	0.023 (0.029)
Vicious Cycle (E)	0.000 (0.000)	0.000 (0.000)
(L)	0.000 (0.000)	0.000 (0.000)
Consequences (E)	0.010 (0.011)	0.047 (0.076)
(L)	0.008 (0.004)	0.046 (0.056)
Direction of consequences:		
patient to other (E)	0.000 (0.000)	0.019 (0.040)
(L)	0.001 (0.001)	0.017 (0.030)
other to patient (E)	0.010 (0.011)	0.028 (0.040)
(L)	0.007 (0.005)	0.027 (0.030)
Compares/Contrasts (E)	0.006 (0.008)	0.001 (0.001)
(L)	0.008 (0.008)	0.004 (0.006)
General Interaction (E)	0.013 (0.018)	0.010 (0.016)
(L)	0.007 (0.006)	0.018 (0.021)

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of therapists' focusing on interpersonal links across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The analysis showed no significant effect of session order, type of therapy, or of the interaction of session order and type of therapy.

Summary

Interpersonal links across early and late sessions

No significant effect of session order or of the interaction of session order and type of therapy was found across early and late sessions and the Cognitive-behaviour and Psychodynamic grouping of therapies.

6.3.5 The Mean Total of Interpersonal and Intrapersonal References and the Ratio of Interpersonal to Intrapersonal References

The mean total rate of therapists' focus on each category of interpersonal links was analysed across early and late sessions and the two therapy groupings. The mean total rate of intrapersonal and interpersonal factors divided by the respective number of coding categories subsumed within each was also calculated across early and late sessions and by type of therapy. These rates are presented for the two therapy groupings in Table 6.22. The table also presents the analyses in a format of the ratio of intrapersonal to interpersonal factors in each grouping.

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the mean total rate of therapists' focusing on intrapersonal and interpersonal links across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The analysis showed no significant effect of session order or of the interaction of session order and type of therapy. It did show however significant effects of type of therapy which replicated findings from the independent samples t-Tests reported earlier (see page 242).

Table 6.22. Mean Rate of Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus in therapist statements and the Ratio of these factors within groups across early and late sessions two therapy groupings (standard deviation in brackets)

Group / Coding Category		Cognitive-behaviour therapies	Psychodynamic psychotherapies
Intrapersonal Total	(E)	0.051 (0.036)	0.202 (0.231)
	(L)	0.027 (0.020)	0.209 (0.231)
Intrapersonal Total/ no of Factors	(E)	0.013 (0.009)	0.051 (0.058)
	(L)	0.007 (0.005)	0.052 (0.058)
Interpersonal Total	(E)	0.035 (0.026)	0.083 (0.114)
	(L)	0.027 (0.019)	0.091 (0.076)
Interpersonal Total/ no of Factors	(E)	0.007 (0.051)	0.017 (0.023)
	(L)	0.005 (0.004)	0.018 (0.015)
Ratio of Intrapersonal to Interpersonal Factors	(E)	1.46 : 1	2.43 : 1
	(L)	1.00 : 1	2.30 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	(E)	1.86 : 1	3.00 : 1
	(L)	1.40 : 1	2.89 : 1

Summary

Mean total of Intrapersonal and Interpersonal references and the Ratio of Intrapersonal to Interpersonal references across early and late sessions

No significant effect of session order or of the interaction of session order and type of therapy was found across early and late sessions and the Cognitive-behaviour and Psychodynamic grouping of therapies.

Inspection of data suggested that intrapersonal totals were higher than interpersonal in early sessions of the Cognitive-behaviour grouping of therapies and early and late sessions of the Psychodynamic grouping.

Inspection of data suggested that the ratio of intrapersonal to interpersonal totals lessened in late over early sessions of both the Cognitive-behaviour and Psychodynamic grouping of therapies.

6.3.6 Who Therapists Focus On

This section of analyses includes testing of the hypothesis that references to the therapist will be higher in late sessions of the Psychodynamic grouping of therapies than in early sessions.

The rate of therapists' focus on each person category across early and late sessions and the two therapy groupings was analysed. Table 6.23 presents the mean rates of each of these categories.

Table 6.23. The mean rate of therapist references to each coding category of Persons Involved of the Coding System of Therapeutic Focus across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patient (E)	0.306 (0.117)	0.497 (0.209)
(L)	0.371 (0.096)	0.473 (0.152)
Therapist (E)	0.039 (0.037)	0.077 (0.112)
(L)	0.042 (0.035)	0.114 (0.087)
Parent (E)	0.008 (0.008)	0.133 (0.098)
(L)	0.003 (0.004)	0.125 (0.145)
Mate (E)	0.022 (0.042)	0.129 (0.208)
(L)	0.026 (0.034)	0.076 (0.156)
Child (E)	0.016 (0.036)	0.016 (0.031)
(L)	0.013 (0.022)	0.022 (0.041)
Dream/Fantasy Figure (E)	0.000 (0.000)	0.009 (0.015)
(L)	0.000 (0.000)	0.006 (0.015)
Acquaintance/Strangers (E)	0.063 (0.061)	0.059 (0.064)
and Others in General (L)	0.075 (0.036)	0.044 (0.059)

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of therapists' focusing on each persons category across the two groupings of therapies, Psychodynamic and Cognitive-behaviour. The analysis showed no significant effect of session order or of the interaction of session order and type of therapy. It did however replicate findings from earlier independent samples t-Tests in showing a significant effect of therapy grouping on references to parents ($F(1, 10) = 10.538$, $p<0.01$) (see page 245). In addition, a paired samples t-Test showed the Psychodynamic grouping of therapies to contain higher mean occurrence of references to the therapist in late sessions than in early ($t(5) = 2.287$, $p<0.05$).

Summary

Who therapists focus on across early and late sessions

Support was obtained for the hypothesis that therapist focus on themselves would be higher in late sessions of the Psychodynamic grouping of therapies than in early sessions.

6.3.7 The Time Frame of Therapists' Interventions

This section of analyses includes testing of the hypothesis that therapist focus on the future time frame will increase in late sessions over early.

The rate of coding of each time frame across early and late sessions and the two therapy groupings was analysed. Table 6.24 presents the mean rates for each of these categories.

Table 6.24. Mean rate of each coding category of Time Frames of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group / Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Pre-Adult Past (E)	0.006 (0.009)	0.091 (0.138)
(L)	0.000 (0.000)	0.024 (0.031)
Adult Past (E)	0.067 (0.126)	0.120 (0.196)
(L)	0.014 (0.011)	0.102 (0.152)
Current (E)	0.102 (0.035)	0.186 (0.178)
(L)	0.147 (0.062)	0.178 (0.118)
In Session (E)	0.047 (0.040)	0.270 (0.273)
(L)	0.036 (0.029)	0.185 (0.185)
Future (E)	0.043 (0.022)	0.012 (0.020)
(L)	0.103 (0.044)	0.043 (0.061)
General (E)	0.100 (0.066)	0.091 (0.115)
(L)	0.120 (0.082)	0.181 (0.139)
Irrelevant/Unspecified (E)	0.131 (0.181)	0.025 (0.029)
(L)	0.098 (0.094)	0.012 (0.013)

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of coding in therapist statements of each time frame across the two therapy groupings. The analysis showed a significant increase in late sessions over early of therapist statements in the future time frame ($F(1, 10) = 7.356$, $p<0.05$). It also showed a significant effect of type of therapy on in-session ($1, 10) = 15.064$, $p<0.001$) and irrelevant or unspecified ($F(1, 10) = 12.025$, $p<0.001$) time frames which replicated findings from earlier independent samples t-Tests (see page 250). There was no significant effect of the interaction of session order and type of therapy.

Summary

Time frames across early and late sessions

Support was obtained for the hypothesis that therapist focus on the future time frame would increase in late sessions over early sessions of therapy.

No significant effect of the interaction of session order and type of therapy was found across the Cognitive-behaviour and Psychodynamic grouping of therapies.

6.3.8 Person Links and Time Links

The rate of linking of time frames and of person categories was analysed across early and late sessions and the two therapy groupings. Mean rates of each of these categories are presented in Table 6.25.

Table 6.25. Mean rate of Time Links and Person Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Time Links (E)	0.006 (0.007)	0.180 (0.226)
(L)	0.005 (0.007)	0.145 (0.172)
Person Links (E)	0.003 (0.005)	0.052 (0.078)
(L)	0.004 (0.005)	0.116 (0.149)

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the rate of linking in therapist statements of time frames and of person categories across early and late sessions and the two groupings of therapies. The analysis showed there to be no significant effect of session order or of the interaction of session order and type of therapy. They did find however significant effects of type of therapy on links of time frames and person categories which replicated the findings of independent samples t-Tests reported above (see page 252).

Summary

Linking of person categories and time frames across early and late sessions

No significant effect of session order or of the interaction of session order and type of therapy was found across the Cognitive-behaviour and Psychodynamic grouping of therapies.

6.4 RESULTS SUMMARY - THE FOCUS OF THERAPISTS' INTERVENTIONS ACROSS THERAPIES

The results of the analyses of therapists' references to each of the individual categories of the Coding System of Therapeutic Focus which have been detailed in this chapter are summarised in the tables beneath. The summaries itemise whether or not each of the various comparisons analysed showed a significant difference across the two therapy groupings and across the six therapy groups.

Table 6.26 presents a summary of comparisons of therapist references to Components of Patient Functioning, General Interventions, Intrapersonal links and Interpersonal links where the main effect analysed was type of therapy. Table 6.27 summarises comparisons of therapist references to Persons Involved, Time Frames, Person Links and Time Links also across type of therapy.

Table 6.28 presents a summary of comparisons of therapist references to Components of Patient Functioning, General Interventions, Intrapersonal links and Interpersonal links where the main effect analysed was the interaction of session order and type of therapy. Finally, Table 6.29 summarises the effect of the interaction of session order and type of therapy on therapist references to Persons Involved, Time Frames, Person Links and Time Links.

Table 6.26. Summary of Results of Comparisons Across Type of Therapy of Therapist References to Components of Patient Functioning, General Interventions, Intrapersonal links and Interpersonal links

	Two Therapy Groupings			Six Therapy Groups		
Reference	Rate	Mean	Percent.	Rate	Mean	Percent.
Comp.of Pt. Functioning:						
Situation	Sig.	Sig.	Sig.	N.S.	N.S.	N.S.
Self Observation	N.S.	N.S.	N.S.	Sig.	Sig.	Sig.
Self Evaluation	N.S.	N.S.	N.S.	Sig.	N.S.	N.S.
Expectations	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
General Thoughts	N.S.	N.S.	N.S.	Sig.	Sig.	Sig.
Intentions	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Emotions	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.
Actions	N.S.	N.S.	N.S.	Sig.	N.S.	N.S.
Gen.Interventions:						
Real-Unreal.	N.S.	N.S.	N.S.	Sig.	Sig.	Sig.
React.of Other	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Theme	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Support	Sig.	Sig.	Sig.	Sig.	N.S.	N.S.
Info. Giving	Sig.	Sig.	Sig.	N.S.	N.S.	N.S.
Changes	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Avoidance	Sig.	Sig.	Sig.	Sig.	N.S.	N.S.
Self Disclosure	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Intrapersonal Links:						
Sim/Patterns	N.S.	N.S.	N.S.	Sig.	N.S.	N.S.
Differences	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Vicious Cycle	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Consequences	N.S.	Sig.	Sig.	Sig.	Sig.	Sig.
Interpersonal Links:						
Patterns	N.S.	Sig.	Sig.	N.S.	N.S.	N.S.
Vicious Cycle	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Consequences	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Dir.of Cons:						
pt.to other	N.S.	N.S.	Sig.	N.S.	N.S.	N.S.
other to pt.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Comp/Contrasts	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Gen.Interaction	N.S.	N.S.	N.S.	Sig..	Sig.	Sig.
Intrapersonal total	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.
Interpersonal total	Sig.	Sig.	Sig.	N.S.	N.S.	N.S.

Table 6.27. Summary of Results of Comparisons Across Type of Therapy of Therapist References to Persons Involved, Time Frames, Person Links and Time Links

	Two Therapy Groupings			Six Therapy Groups		
Reference	Rate	Mean	Percent.	Rate	Mean	Percent.
Persons Involved:						
Patient	N.S.	N.S.	N.S.	Sig.	Sig.	N.S..
Therapist	Sig.	Sig.	Sig.	N.S.	N.S.	N.S.
Parent	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.
Mate	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Child	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Dream Figure	N.S.	N.S.	N.S.	Sig.	Sig.	Sig.
Others	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Time Frames:						
Pre-Adult Past	Sig.	N.S.	N.S.	N.S.	N.S.	N.S..
Adult Past	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Current	N.S.	N.S.	N.S.	Sig.	N.S.	N.S.
In Session	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.
Future	Sig.	Sig.	Sig.	N.S.	N.S.	N.S.
General	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Irrelevant	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.
Person Links	Sig.	Sig.	Sig.	N.S.	N.S.	N.S.
Time Links	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.

Table 6.28. Summary of Results of the Effect of the Interaction of Session Order and Type of Therapy on Therapist References to Components of Patient Functioning, General Interventions, Intrapersonal links and Interpersonal links

	Two Therapy Groupings		
Reference	Rate	Mean	Percent.
Comp. of Pt. Functioning:	N.S.	N.S.	N.S.
Situation	N.S.	N.S.	N.S.
Self Observation	N.S.	N.S.	N.S.
Self Evaluation	N.S.	N.S.	N.S.
Expectations	N.S.	N.S.	N.S.
Gen. Thoughts	N.S.	N.S.	N.S.
Intentions	N.S.	N.S.	N.S.
Emotions	N.S.	N.S.	N.S.
Actions	N.S.	N.S.	N.S.
Gen.Interventions:			
Real-Unreal.	N.S.	N.S.	N.S.
Reaction of Other	N.S.	N.S.	N.S.
Theme	N.S.	N.S.	N.S.
Support	Sig.	Sig.	Sig.
Information	N.S.	N.S.	N.S.
Changes	N.S.	N.S.	N.S.
Avoidance	N.S.	N.S.	N.S.
Self Disclosure	N.S.	N.S.	N.S.
Intrapersonal Links:			
Sim/Patterns	N.S.	N.S.	N.S.
Differences	N.S.	N.S.	N.S.
Vicious Cycle	N.S.	N.S.	N.S.
Consequences	N.S.	N.S.	N.S.
Interpersonal Links:			
Patterns	N.S.	N.S.	N.S.
Vicious Cycle	N.S.	N.S.	N.S.
Consequences	N.S.	N.S.	N.S.
Dir.of Cons.:			
patient to other	N.S.	N.S.	N.S.
other to patient	N.S.	N.S.	N.S.
Comp/Contrasts	N.S.	N.S.	N.S.
Gen.Interaction	N.S.	N.S.	N.S.
Intrapersonal total	N.S.	N.S.	N.S.
Interpersonal Total	N.S.	N.S.	N.S.

Table 6.29. Summary of Results of the Effect of the Interaction of Session Order and Type of Therapy on Therapist References to Persons Involved, Time Frames, Person Links and Time Links

	Two Therapy Groupings		
Reference	Rate	Mean	Percent.
Persons Involved:			
Patient	N.S.	N.S.	N.S.
Therapist	N.S.	N.S.	N.S.
Parent	N.S.	N.S.	N.S.
Mate	N.S.	N.S.	N.S.
Child	N.S.	N.S.	N.S.
Dream Figure	N.S.	N.S.	N.S.
Others	N.S.	N.S.	N.S.
Time Frames:			
Pre-Adult Past	N.S.	N.S.	N.S.
Adult Past	N.S.	N.S.	N.S.
Current	N.S.	N.S.	N.S.
In Session	N.S.	N.S.	N.S.
Future	N.S.	N.S.	N.S.
General	N.S.	N.S.	N.S.
Irrelevant	N.S.	N.S.	N.S.
Person Links	N.S.	N.S.	N.S.
Time Links	N.S.	N.S.	N.S.

6.5 DISCUSSION

6.5.1 Components of Patient Functioning

Therapists in the psychodynamic grouping of therapies focused more frequently on patients' emotions than did therapists in the cognitive-behaviour grouping. Analyses across the six therapy groups also showed therapist focus on patient emotion to be higher in the psychoanalytic psychotherapy group than the other five therapy groups and higher in the psychodynamic psychotherapy group than the three cognitive-behaviour groups. This finding was unsurprising with the central place given in psychodynamic psychotherapies to the exploration, insight and readjustment to patients' emotional lives. What was more surprising given the similar central place of patients' thoughts in cognitive-behaviour therapies was that therapists in the cognitive-behaviour grouping did not focus more on thoughts than therapists in the psychodynamic grouping. In fact

they focused on them less although the difference was not significant. Inspection of data across the six therapy groups showed therapists in the cognitive-behaviour, cognitive, conversational and psychoanalytic therapy groups to have comparable levels of focus on thoughts, with the psychodynamic group having a higher level and the behaviour therapy group a lower level (on percentage and mean data but not rate). Thus the psychodynamic psychotherapy group had a significantly higher level of therapist focus on thoughts than the psychoanalytic group. This had been hypothesised and gave support to the view that short term psychodynamic psychotherapy was a more cognitive process than psychoanalytic psychotherapy giving patients intellectual insight into the underlying dynamics of presenting difficulties. Also surprising given the behavioural component of cognitive-behaviour therapies was that the cognitive-behaviour grouping did not focus significantly more than the psychodynamic grouping on patients' actions. Inspection of data showed the psychoanalytic group to contain a higher level of therapist focus on actions and the psychodynamic a lower level than the remaining therapies which had comparable levels to each other. More predictably, the cognitive-behaviour grouping of therapies had a higher focus on situations than did the psychodynamic grouping and the behaviour, cognitive-behaviour and cognitive therapy groups had comparable levels which tended to be higher than the comparable levels of the conversational, psychodynamic and psychoanalytic psychotherapy groups.

6.5.2 General Interventions

As was expected, therapists' statements in the cognitive-behaviour grouping of therapies contained a higher level of direct support and reassurance, the giving of general information, and self-disclosure than therapists' statements in the psychodynamic grouping. The giving of support decreased in late over early sessions of the psychodynamic grouping of therapies, but this only reflected therapist activity in the conversational therapy group; there were no incidences of therapist giving of support in the psychodynamic and psychoanalytic psychotherapy groups. This absence of giving support as coded by the Coding System of Therapeutic Focus did not preclude these therapies giving, they would argue, support through other means, for example the provision of an empathic human environment (cf. Kohut, 1981; Wolf, personal communication).

Therapist giving of information also decreased, as predicted, in late over early sessions of the psychodynamic grouping of therapies; the expectation having been that some guidance would be given in early sessions and then quickly tail off. This again solely reflected activity in the conversational group; there was no giving of information in the psychodynamic and psychoanalytic psychotherapy groups.

Therapist self disclosure was more common in the cognitive-behaviour grouping of therapies than the psychodynamic. Across the six therapy groups, whilst there were comparable levels of self disclosure in the cognitive-behaviour, cognitive and conversational therapy groups, there were no incidences in the psychoanalytic and psychodynamic psychotherapy groups and a high incidence in the behaviour therapy group. The traditional psychoanalytic stance (e.g. Fenichel, 1946, Brenner, 1979) has been one of neutrality; the therapist as a blank screen. But there have always been psychoanalysts (eg Ferenczi, 1914), and increasingly so, who have emphasised the 'personal involvement' of the therapist in a 'real' relationship with the patient as a major mutative force alongside interpretation (e.g Winnicott, 1965; Kohut, 1977; Wolf, 1988). This valuing of a collaborative relationship has not tended to extend to personal revelation by therapists (though there are exceptions e.g. Weiner, 1978; Wolf, 1983) which is seen as likely to be counter-therapeutic and inhibiting of the transference relationship (cf. Waterhouse and Strupp, 1984). It is probable that the absence of self disclosure in the psychodynamic and psychoanalytic groups reflects this view. Other therapeutic approaches may more readily embrace judicious use of self disclosure to, for example, 'normalise' a patient's experience or to 'model' disclosure. The cognitive-behaviour, cognitive and conversational therapy groups showed such judicious use. So too did the behaviour therapy group apart from the high level of disclosure by one therapist in one session which elevated the group mean. Judicious use aside, Hobson's (1989) view generally holds that, "for the most part, ...confessions are one way: there is an asymmetry. It is not the job of a therapist to burden a patient with details of his or her problems" p.27. So too does Dies' (1977) view, from a summary of research, that therapist self disclosure is a relatively ineffective way of trying to promote the same in patients, and may have the undesired 'side-effect' of the disclosing therapist being viewed as 'mentally unhealthy'. Dies (1977) reasonably argues that the usefulness or otherwise of therapist self disclosure is too general a question which needs to be considered with more specificity, e.g. when, in what type of therapy, with what patient group, with what in mind ? Further research could usefully explore this.

The psychoanalytic psychotherapy group had a higher level of therapist focus on reality-unreality, that is facilitating patients stepping back from a subjective perception to a more objective one, than did other groups. Given the commonly held view that cognitive therapies challenge patients' erroneous and subjective views of themselves and the world (e.g through 'decentering' techniques) whereas psychodynamic psychotherapies immerse themselves in the internal (subjective) world of the patient (Kerr et al, 1992, Prochaska, 1979), this may at first sight a surprising finding. However criteria for the coding of reality-unreality embraced therapist interventions, common in the psychoanalytic group, which questioned patients' transferential perspective of themselves and

others through, for example, suggestion, clarification, interpretation and confrontation (cf. Menninger and Holzman, 1973).

6.5.3 Intrapersonal and Interpersonal Links and Ratio

Psychodynamic psychotherapies are commonly considered to be interpersonal in focus and cognitive-behaviour therapies to be intrapersonal (Goldsamt et al, 1992). This was questioned in Chapter One and it was argued that psychoanalysis has an intrapersonal focus too, on the interaction between components of the patient's internal world (Cooper,1987). The findings here with respect to intrapersonal links provide support for this contention. Three of the four possible intrapersonal links: similarity/patterns, difference/incongruity and consequences, were coded more frequently in the psychodynamic grouping of therapies than in the cognitive-behaviour though only one, intrapersonal consequences, was significantly so. The psychoanalytic psychotherapy group had a higher frequency of coding of intrapersonal consequences than other groups and also focused more often on intrapersonal similarity/patterns than the behaviour, cognitive and conversational therapy groups.

Goldsamt et al (1992), as detailed in Chapter One, argued that psychodynamic psychotherapies focus more on the impact of patients on those around them whereas cognitive-behaviour therapies focus more on the impact of others on the patient. This study found support for the former but not the latter. Therapists in the psychodynamic grouping of therapies focused not only more often on patients' impact on others but also on others impact on the patient, although the latter was not significant.

The psychodynamic grouping of therapies also had a higher level of therapist statements focusing on patterns in a patient's interpersonal functioning over time, situations or people.

Kerr et al (1992) have also cast doubt on the commonly expressed view that psychodynamic psychotherapies are interpersonal in focus and cognitive-behaviour therapies intrapersonal. They found that, as they expected, psychodynamic therapists made more interpersonal links than intrapersonal, but that contrary to theoretical expectations so too did cognitive-behaviour therapists. They also found no difference between the therapies in their emphasis on intrapersonal and interpersonal links. However, their research was limited. They used just one cognitive-behaviour and one psychodynamic therapy, the latter being the same conversational therapy researched in this study and which was found on many analyses to be closer to the cognitive-behavioural than the other psychodynamic therapies. They also researched just two clinicians' work, had a low interater reliability, and did not control for the length of therapists' statements.

This study found that both therapy groupings made more intrapersonal links than interpersonal and that the psychodynamic grouping of therapies had a higher total of intrapersonal links than did the cognitive-behaviour grouping. This higher mean total rate reflected activity in the psychoanalytic and psychodynamic psychotherapy groups and provided support for the intrapersonal focus of these therapies that was argued in Chapter One. This study also found the psychodynamic grouping of therapies to have a higher total of interpersonal links than the cognitive-behaviour grouping. This higher total tended to reflect more the activity of the conversational and psychodynamic psychotherapy groups rather than the psychoanalytic and provided support for the view put forward in Chapter One that "analysts ...acknowledge the interpersonal aspect, but they are likely to see it as part of the surround rather than a core of analytic work." (Cooper (1987), p.90).

There was a significant level of therapist interpersonal links in both cognitive-behaviour and psychodynamic therapies in this study and in Kerr et al's (1992). They found however that it was only in psychodynamic psychotherapy that a focus on such links correlated with improvement in patients' self esteem and social adjustment. Despite this they wondered whether in cognitive-behaviour therapy there is the potential for an intrapersonal focus to be synergistically added to with an interpersonal one leading to greater effectiveness. Importantly they note that the high level of interpersonal focus by cognitive-behaviour therapists is a deviation from theory. They thereby implicitly point to a possible benefit to cognitive-behaviour therapy from further embracing an interpersonal perspective and, it may be argued, one which informs the patient-therapist relationship and its therapeutic use.

6.5.4 Who Therapists Focus On

Goldsamt et al (1992) argued that cognitive-behaviour therapists focused more on mates and others in general, and Kerr et al (1992) that psychodynamic psychotherapists focused more on themselves and parents. The present study did not provide support for Goldsamt et al's (1992) views. Therapist focus on general others was higher in the cognitive-behaviour therapy grouping but not significantly so and therapist focus on mates was actually lower. Support was forthcoming however for Kerr et al's (1992) views. Therapists in the psychodynamic grouping focused more on themselves and on parents than therapists in the cognitive-behaviour grouping. Analyses also showed that therapists in the psychodynamic psychotherapy group focused more on parents than other therapists including psychoanalytic. This provided further support for the view that psychodynamic psychotherapy focuses more on genetic reconstruction and psychoanalytic

psychotherapy rather more on the patients current internal world and therefore potentially exploration of patients' dreams. Support for this was provided by analyses showing the psychoanalytic psychotherapy group contained codings of therapist focus on dream or fantasy figures which no other therapy did.

6.5.5 The Time Frame of Therapists' Interventions

Cognitive-behaviour therapies are generally considered to focus on current and future time frames and psychodynamic on current and past (cf. Castonguay et al, 1995). In Chapter One it was suggested that psychodynamic psychotherapy did focus on current and past time frames but that it could be argued that psychoanalytic psychotherapy functioned primarily in the current time frame exploring the patient's current internal world albeit built upon early life experiences. The present study, as expected, found no significant difference between the two groupings in their focus on a current time frame and a higher level of focus in the cognitive-behaviour grouping on a future time frame. It also found the psychodynamic grouping to focus more on a past time frame than the cognitive-behaviour grouping and the psychodynamic psychotherapy group to focus more than the other five therapy groups, though neither differences were significant.

In line with the view that psychoanalytic psychotherapy focuses more than psychodynamic on patients' immediate internal world, the psychoanalytic group had a higher level of in-session focus than the other five therapy groups and the psychodynamic a higher level than just the behaviour and cognitive-behaviour groups.

The differing emphasis of time frames across psychodynamic and psychoanalytic psychotherapies reflects differing views of transference and the role of transference interpretation. Freud (1940) believed transference was a true reconstruction of the past,

> the patient is not satisfied with regarding the analyst in the light of reality as a helper and advisor ... On the contrary, the patient sees in him the return, the reincarnation, of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions which undoubtedly applied to this prototype... the patient produces before us with plastic clarity an important part of his life-story...". (pp.174-176).

By contrast, Kernberg (1987) viewed transference as derived from internalised object relations and conceives of these "as not reflecting actual object relations from the past. Rather, they reflect a combination of realistic and fantasised - and often highly distorted - internalizations of such past object relations and defenses against them." (p.202). He stresses the function of the in-session focus, "it is crucial to first uncover the unconscious meanings of the transference in the here-and-

now and to make fully conscious the expression of this object relation in the transference before attempting reconstruction of the past." (p.211). He is thus substantially in agreement with Gill (1982) in strongly emphasising analysis of the unconscious meaning of transference in the here and now. They differ though in that Kernberg views Gill as blurring together transferences into a unitary amalgam of past and present whereas he places more emphasis on "the differentiation of what is inappropriate in the here-and-now and needs to be explained by its origin elsewhere." (p.217).

Freud's view of transference was of it as an enactment of an earlier relationship, a displacement. For him, transference interpretation aimed to provide insight into the ways in which early life relationships are distorting the current relationship with the therapist and facilitate the patient re-experiencing and adjusting to pathogenic early life experience. An alternative view, such as Kernberg's, would be to view transference as a new experience, as opposed to an enactment, in which transference interpretation aims to provide the patient with insight into current life thoughts, feelings and behaviour within the relationship with the therapist but as influenced by the past. Cooper (1987) calls these views the *historical* and the *modernist* views respectively. The historical view of the therapist is as a blank screen, the modernist view is of the therapist as a co-participant in a working relationship which focuses on the patient's shifting self and object representations within that relationship.

This changing view of transference and transference interpretation may be seen, argues Cooper (1987), as "the most visible emblem of the deep changes in psychoanalytic theory that are now quietly taking place and of the theoretical pluralism that is prevalent today." (p.80). In noting the context of these changes Cooper refers to Kermode (1985) who argued there was a change during the 20th century in how we understand and interpret the past and the present; a change from understanding how things are by looking to their evolution, to one of understanding them by examining their current composition. Kermode draws on linguists' distinction (cf. de Saussure, 1915) between diachrony, the study of how things came to be, and synchrony, the study of how things are. In the consulting room, this translates to a technical emphasis on transference exploration of the here and now and a downgrading of genetic reconstruction. A move that is from understanding the present through the past to understanding the present, and how the past influences it, whilst accepting that we can only understand the past through the present, and construct rather than reconstruct the past. Cooper suggests this is part of a varying emphasis across analysts and across time between cognition and affect. The classical Freudian view of transference was a more cognitive one, an objective science, with an intellectual archaeology to uncover historical truth. Although interestingly Lipton (1977) argues that the so called classical Freudian

technique marked by restraint and utilising only interpretation was in fact developed in the 1940s and 1950s and was a marked distortion of Freud's more relaxed, responsive and "mature analytic technique". The modernist view is a more affective one with transference interpretation geared to remove impediments to the immediacy of the patient-therapist relationship as well as to the gaining of insight.

Perhaps it makes sense, as Emde (1981) writes:

> for the psychoanalyst to place renewed emphasis on recent and current experience - first, as a context for interpreting early experience and second, because it contains within it the ingredients for potential amelioration.... Psychoanalysts are specialists in dealing with the intrapsychic world and in particular with the dynamic unconscious. But we need to pay attention not only to the intrapsychic realm, conflict-laden and conflict-free, but also to the interpersonal realm. ..... we have probably placed far too much emphasis on early experience itself as opposed to the process by which it is modified or made use of by subsequent experience." (pp.218-219).

CHAPTER 7

RESULTS

THERAPISTS' RESPONSE TO PATIENTS' NEGATIVE MATERIAL

This chapter presents results of the analysis of therapists' response to patients' explicitly and implicitly expressed negative material about therapy and the therapist.

Data are presented first which give information on the reliability of the identification of patient negative material and the coding of therapist response to it. Brief descriptive information is then given on the therapy sessions from which data were obtained. This is followed by the presentation of results where the main effect analysed was the type of therapy, and finally results where the main effect analysed was the interaction of session order with therapy type i.e. the comparison across therapies of sessions from early in therapy with those from late in therapy.

In investigating the effect of type of therapy analyses were undertaken across the six therapy groups: behaviour, cognitive-behaviour, cognitive, conversational, psychodynamic and psychoanalytic and also across the two therapy groupings: Cognitive-behaviour (behaviour, cognitive-behaviour and cognitive) and Psychodynamic (conversational, psychodynamic and psychoanalytic).

In investigating the effect of session order the unit of analysis was the specific patient-therapist pair. Thus, sessions from early in therapy of a patient-therapist pair were compared with sessions from late in the same therapy. The early sessions were taken from the first five sessions of therapy but not the first and compared with late sessions taken from the last five sessions of therapy but not the last. The one exception to this was late sessions of psychoanalytic psychotherapy where sessions were taken from the last two months of therapies all of which exceeded two years. In considering the interaction of session order and therapy type only the results of analyses of the two therapy groupings are presented and discussed. This is because the limited numbers in each of the 12 conditions of the two-way analysis of variance across six therapy groups limit the detection of experimental effects and their generalisability. Analyses across the six therapy groups are reported in Appendix 10.

Analyses of patients' negative material drew (as did the preceding analyses of transference references and the focus of therapists' interventions) on three sources of data:

i) percentage (patient) - the percentage of statements per session containing the item being analysed

ii) mean - the occurrence per statement of the item being analysed

iii) rate - the occurrence per line of statement of the item being analysed

As previously noted (see page 228) measures of rate have the advantage of controlling for differences in statement and session length between therapy groups. There was limited variation between the three measures in the differences they identified in comparisons of transference references and therapist focus between therapy groups. Therefore only the results of analyses of measures of rate of patient negative material are presented in the main text; unless there are significant differences between these and analyses of percentages and means. Analyses of percentages and means are presented in full in Appendix 10.

To analyse therapists' various responses to patient negative material, data was also drawn from two further perspectives:

i) number - the number of patient statements per session containing the negative material being analysed

ii) percentage (therapist) - the number of responses of a particular sort to patient negative material expressed as a percentage of the total number of responses

7.1 Reliability of Identification of Patient Negative Material

A Psychologist previously independent of the research study was trained in the identification of patient negative material and the coding of therapist response to it. This training included familiarisation with the Therapist Response (Facilitative-Restrictive) Rating Scale, conjoint trial ratings with the author of transcriptions not used in the study, and independent trial ratings of transcriptions not used in the study followed by discussion meetings with the author. Subsequent to this training period all therapy sessions included in this part of the study were independently rated by the author and by the Psychologist. Where there were discrepancies between the two ratings these were resolved by discussion which also involved a third rater, a Consultant Clinical Psychologist who was also an experienced Psychoanalytic Psychotherapist.

The identification of patient negative material showed good reliability with high percentage agreements between raters overall and on both explicitly and implicitly expressed negative material. These percentage agreements are presented in Table 7.1. The author also gave a *degree of confidence* score of between '1' (low) and '7' (high) to each of his ratings. Percentage agreements for explicit and for implicit negative material are presented for each of these *degree of confidence* scores in Table 7.2.

Table 7.1. Percentage Agreement between Raters of Negative Patient Material

	Agreement	Disagreement
Overall	82.10	17.90
Explicit	92.96	7.04
Implicit	78.71	21.29

Table 7.2. Percentage Agreement between Raters of Negative Patient Material by Degree of Confidence Scores

Degree of Confidence Score	No. of Scores as percentage of total	Agreement	Disagreement
Explicit			
7	51.82	98.59	1.41
6	18.98	92.31	7.69
5	12.14	94.12	5.88
4	6.87	77.78	22.22
3	8.00	100.00	0.00
2	2.19	100.00	0.00
1	0.00	-	-
Implicit			
7	11.18	96.15	3.85
6	15.70	86.30	13.70
5	12.26	84.21	15.79
4	15.70	80.82	19.18
3	18.92	75.00	25.00
2	17.85	73.49	26.51
1	8.39	61.54	38.46

Inspection of ratings where there was disagreement between the two raters showed 81.03% consisted of the independent rater not rating an item identified by the author as implicit negative material and 1.80% consisted of the independent rater not rating an item identified by the author as explicit negative material. A further 9.91% of cases consisted of the author not rating an item identified by the independent rater as implicit negative material and 3.57% of not rating an item identified by the independent rater as explicit negative material. In 0.09% of cases negative material rated as explicit by the author was rated as implicit by the independent rater and in 3.57% of cases negative material rated as implicit by the author was rated as explicit by the independent rater.

7.2 Reliability of Rating of Therapist Response to Patient Negative Material

Therapist response to patient negative material was independently rated by the author and by the Psychologist, trained in the use of the Therapist Response (Facilitative-Restrictive) Rating Scale, who rated patient negative material (see page 278). Where there were discrepancies between the two ratings these were resolved by discussion which also involved a third rater, a Consultant Clinical Psychologist who was also an experienced Psychoanalytic Psychotherapist.

The rating of therapist response showed good reliability with high percentage agreements between raters on the coding of therapists' responses as facilitative or as restrictive or as 'no responses'. These percentage agreements are presented in Table 7.3. Further information is provided, in Table 7.4 of percentage agreements of the specific rating scores.

The levels of percentage agreements achieved both on the identification of patient negative material and the rating of therapist response to it suggested good reliability and an absence of bias in the author's ratings.

Table 7.3. Percentage Agreement between Raters of Category of Therapist Response to Negative Patient Material

Therapist Response	No. of Responses as percentage of total responses	Agreement	Disagreement
Facilitative	41.54	79.98	20.02
Restrictive	27.59	85.19	14.81
No Response	30.87	83.62	16.38

A Spearman Rank Correlation Coefficient showed there to be significant correlation between the therapist response rating scores of the two raters and this is further detailed in Table 7.5.

Table 7.4. Percentage Agreement between Raters of Scores of Therapist Response to Negative Patient Material

Therapist Response	No. of Responses as percentage of total responses	No. of Responses as percentage of facilitative or restrictive responses	Agreement	Disagreement
Facilitative				
+3	7.78	17.93	87.50	12.50
+2	9.14	21.08	72.34	27.66
+1	26.46	60.99	80.80	19.20
0	24.32	-	83.62	16.38
Restrictive				
-1	17.51	54.21	88.89	11.11
-2	10.12	31.33	75.00	25.00
-3	4.67	14.46	91.67	8.33

Table 7.5. Correlation between the Two Raters Scores of Therapist Response to Patient Negative Material

Therapist Response	Spearman Rank Order Correlation (r_s)	Probability
Facilitative		
+3	0.83	<0.01
+2	0.67	<0.01
+1	0.71	<0.01
0	0.76	<0.01
Restrictive		
-1	0.85	<0.01
-2	0.71	<0.01
-3	0.99	<0.01

7.3 Descriptive Data on Therapy Sessions

a) Session length

The mean length in minutes of sessions in each of the six therapy groups is presented in Table 7.6. As with the sessions analysed in previous chapters those of the Psychodynamic and Psychoanalytic group averaged about 50 minutes with little deviation; those in the Cognitive group about an hour and ten minutes with much variation, and those in the Behaviour, Cognitive-behaviour and Conversational groups between 50 and 60 minutes with the Behaviour therapy group sessions showing a large variation in length.

Table 7.6. Length in Minutes of Sessions

Therapy Group	Mean	Standard Deviation
Behaviour	56.71	43.26
Cognitive-behaviour	52.42	19.78
Cognitive	68.31	21.26
Conversational	53.29	9.01
Psychodynamic	50.16	0.89
Psychoanalytic	50.04	0.62

b) Word Length of Transcriptions

The mean length in words of sessions across the six therapy groups is presented in Table 7.7. As with the sessions analysed in previous chapters those of the Behaviour group showed a wide variation in length, between 3000 and 13500 words.

Table 7.7. Word Length of Session Transcriptions

Therapy Group	Mean	Standard Deviation
Behaviour	8655.75	4692.76
Cognitive-behaviour	8035.75	1445.53
Cognitive	9365.25	2384.72
Conversational	6595.75	1229.00
Psychodynamic	4810.50	744.79
Psychoanalytic	570.00	350.81

c) Number of Patient-Therapist Statements in Sessions

The mean number of pairs of patient-therapist statements in sessions across the six therapy groups is presented in Table 7.8.

Table 7.8. Number of Pairs of Patient-Therapist Statements in Sessions

Therapy Group	Mean	Standard Deviation
Behaviour	222.50	147.61
Cognitive-behaviour	77.75	18.10
Cognitive	159.25	55.04
Conversational	51.00	15.12
Psychodynamic	52.50	3.11
Psychoanalytic	5.75	2.75

d) Length of Patient and Therapist Statements in Sessions

The mean length in lines of patient statements and of therapist statements in each of the six therapy groups is presented in Table 7.9. The mean total number of lines in a session of patient statements and of therapist statements is presented in Table 7.10 for each of the six therapy groups.

Table 7.9. The Length (number of lines) of Patient and Therapist Statements in Sessions

	Patient		Therapist	
Therapy Group	Mean	SD	Mean	SD
Behaviour	2.15	1.56	1.40	0.22
Cognitive-behaviour	4.41	1.61	4.63	1.73
Cognitive	2.44	0.44	3.55	0.42
Conversational	6.90	1.45	2.59	0.62
Psychodynamic	5.50	1.22	1.83	0.38
Psychoanalytic	11.06	5.99	1.58	0.49

Table 7.10. The Total Length (number of lines) of Patient and Therapist Statements per Session

Therapy Group	Patient		Therapist	
	Mean	SD	Mean	SD
Behaviour	415.23	276.22	301.19	178.79
Cognitive-behaviour	350.57	170.86	336.78	21.71
Cognitive	382.91	147.11	547.38	135.58
Conversational	342.00	77.51	130.72	40.91
Psychodynamic	288.39	63.75	95.79	17.44
Psychoanalytic	53.56	18.57	9.95	7.69

7.4 Patients' Expressed Negative Material Across Therapies

This section of analyses includes testing of the hypotheses that:

i) there will be no difference between the Cognitive-behaviour and Psychodynamic grouping of therapies in the level of patients' explicit negative material

ii) the Cognitive-behaviour grouping of therapies will have a higher level of patient implicit negative material than the Psychodynamic grouping

iii) the Psychodynamic and Psychoanalytic psychotherapy groups will have a lower level of patient implicit negative material than the Behaviour, Cognitive-behaviour and Cognitive therapy groups

iv) the Cognitive-behaviour grouping of therapies will have a higher level of patient combined explicit and implicit negative material than the Psychodynamic grouping

Results are presented of the number of patient statements in sessions containing negative comment about the therapy or therapist and the rate of such references.

Results of the number of patient statements in sessions containing negative comments analysed across the two therapy groupings, Cognitive-behaviour and Psychodynamic, are detailed in Table 7.11 along with categorised therapists' responses to these negative comments. Results are presented of analyses across the six therapy groups in Table 7.12 along with categorised therapists' responses to these negative responses. Results of analyses of the rate of negative comments across the two therapy groupings are presented in Table 7.13 and across the six therapy groups in Table 7.14.

7.4.1 Patients' explicitly expressed material

The Two Therapy Groupings

Independent Samples t-Tests were used to compare, across the Cognitive-behaviour and Psychodynamic grouping of therapies, the number of patient statements in sessions containing explicitly expressed negative material about the therapist or therapy and their rate. The tests did not show any significant difference between the two groupings on these measures.

The Six Therapy Groups

A one-way ANOVA for the number of patient statements containing explicit references to negative material about the therapist or therapy found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 5.350$, $p<0.005$). However, further analyses did not find a significant difference between any two of the six therapy groups.

A further one-way ANOVA did not find any significant effect of type of therapy across the six groups on the rate of patient explicitly expressed negative material about the therapist or therapy.

Table 7.11. The Number of Patient Statements Containing Negative Comments and the Number of Therapist Statements Containing Each Category of Response, Across the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient/therapist Category				
Patient:				
Explicit	4.67	(5.24)	4.25	(4.92)
Implicit	24.08	(13.45)	9.83	(6.09)
Expl.& Impl.	28.75	(16.88)	14.08	(10.27)
Therapist Facilitative response to:				
Explicit	1.83	(2.41)	3.25	(3.89)
Implicit	6.42	(7.49)	7.08	(4.87)
Expl.& Impl.	8.25	(9.33)	10.33	(8.37)
Therapist Restrictive response to:				
Explicit	2.08	(2.43)	0.42	(0.67)
Implicit	10.25	(4.81)	1.08	(2.02)
Expl.& Impl.	12.33	(6.26)	1.50	(2.54)
Therapist No Response to:				
Explicit	0.75	(0.87)	0.75	(1.06)
Implicit	7.42	(4.36)	1.50	(1.57)
Expl.& Impl.	8.17	(4.71)	2.25	(1.42)

Table 7.12. The Number of Patient Statements Containing Negative Comments and the Number of Therapist Statements Containing Each Category of Response, Across the Six Therapy Groups (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
		Cog.-behaviour		Conversational		Psychoanalytic
Patient/Therapist Category						
Patient:						
Explicit	2.25	0.75	11.00	7.25	5.00	0.50
	(3.30)	(0.96)	(2.71)	(5.85)	(4.69)	(1.00)
Implicit	16.50	20.50	35.25	15.25	11.00	3.25
	(8.18)	(3.87)	(17.93)	(3.95)	(4.24)	(1.89)
Expl.& Impl.	18.75	21.25	46.25	22.50	16.00	3.75
	(7.09)	(4.35)	(18.95)	(9.33)	(7.35)	(2.06)
Therapist Facilitative response to:						
Explicit	0.75	0.25	4.50	5.00	4.50	0.25
	(0.96)	(0.50)	(2.38)	(3.92)	(4.65)	(0.50)
Implicit	1.50	6.00	11.75	10.25	8.75	2.25
	(2.38)	(2.45)	(11.12)	(5.12)	(3.30)	(1.26)
Expl.& Impl.	2.25	6.25	16.25	15.25	13.25	2.50
	(2.63)	(2.22)	(13.00)	(9.00)	(6.99)	(1.29)
Therapist Restrictive response to:						
Explicit	1.00	0.25	5.00	1.00	0.25	0.00
	(1.41)	(0.50)	(1.41)	(0.82)	(0.50)	(0.00)
Implicit	7.25	9.25	14.25	2.50	0.75	0.00
	(4.11)	(4.50)	(3.59)	(3.11)	(0.96)	(0.00)
Expl.& Impl.	8.25	9.50	19.25	3.50	1.00	0.00
	(3.30)	(4.80)	(3.59)	(3.70)	(1.15)	(0.00)
Therapist No Response to:						
Explicit	0.50	0.25	1.50	1.25	0.75	0.25
	(1.00)	(0.50)	(0.58)	(1.50)	(0.96)	(0.50)
Implicit	7.75	5.25	9.25	2.50	1.00	1.00
	(5.12)	(3.40)	(4.57)	(2.38)	(0.82)	(0.82)
Expl.& Impl.	8.25	5.50	10.75	3.75	1.75	1.25
	(5.12)	(3.87)	(4.65)	(1.26)	(0.50)	(0.96)

Table 7.13. The Rate of Patient Negative Comments Across the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient/therapist Category				
Explicit	0.01	(0.02)	0.02	(0.02)
Implicit	0.07	(0.03)	0.09	(0.07)
Expl.& Impl.	0.07	(0.03)	0.09	(0.07)

Table 7.14. The Rate of Patient Negative Comments Across the Six Therapy Groupings (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-behaviour		Conversational		Psychoanalytic
Patient/Therapist Category						
Explicit	0.01	0.01	0.03	0.03	0.02	0.01
	(0.01)	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)
Implicit	0.06	0.08	0.09	0.07	0.05	0.14
	(0.04)	(0.04)	(0.03)	(0.04)	(0.02)	(0.10)
Expl. & Impl.	0.06	0.08	0.09	0.07	0.05	0.14
	(0.04)	(0.04)	(0.03)	(0.04)	(0.02)	(0.10)

7.4.2 Patients' implicitly expressed material

The Two Therapy Groupings

An Independent Samples t-Test was used to compare, across the Cognitive-behaviour and Psychodynamic grouping of therapies, the number of patient statements in sessions containing implicitly expressed negative material about the therapist or therapy and the rate of such references. The test showed the Cognitive-behaviour grouping to contain a significantly higher number of implicitly expressed negative comments than did the Psychodynamic grouping ($t(22) = 3.343$, $p<0.005$).

The Six Therapy Groups

A one-way ANOVA for the number of patient statements containing implicit references to negative material about the therapist or therapy found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 6.248$, $p<0.005$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a significantly lower number of such references than did the Cognitive therapy group ($t(18) = 4.001$, $p<0.001$) and the Psychoanalytic psychotherapy group a significantly lower number than the Behaviour ($t(18) = 2.186$, $p<0.05$), Cognitive-behaviour ($t(18) = 2.846$, $p<0.05$) and Cognitive ($t(18) = 5.280$, $p<0.001$) therapy groups.

No other analyses of patients' implicit negative references showed any significant differences either across the two therapy groupings or the six therapy groups.

7.4.3 Patients' explicitly and implicitly expressed material

The Two Therapy Groupings

An Independent Samples t-Test was used to compare, across the Cognitive-behaviour and Psychodynamic grouping of therapies, the combined number of explicit and implicit negative comments about the therapy or therapist in patient statements. The test show the Cognitive-behaviour grouping to contain a significantly higher combined number of explicitly and implicitly expressed negative comments than did the Psychodynamic grouping ($t(22) = 2.571$, $p<0.05$). However, conversely an Independent Samples t-Test test show the Psychodynamic grouping to contain a significantly higher combined percentage than the Cognitive-behaviour grouping ($t(22) = 3.520$, $p<0.005$).

The Six Therapy Groups

One-way ANOVAs for the combined number and combined percentage of explicit and implicit references to negative material about the therapist or therapy found significant effects of type of therapy across the six therapy groups ($F(5, 18) = 8.091$, $p<0.001$ and $F(5, 18) = 8.864$, $p<0.001$ respectively). Further analyses showed the Cognitive therapy group to contain a higher number of such references than did the Psychoanalytic therapy group (Scheffe test, $p<0.001$) and the Psychoanalytic psychotherapy group to contain a higher percentage of such references than did the Behaviour therapy group (Scheffe test, $p<0.001$).

No other analyses of patients' combined explicit and implicit negative references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Patient negative material

Support was obtained for the hypothesis that there would be no difference between the Cognitive-behaviour and the Psychodynamic grouping in the level of explicit negative material. There was also no difference in the level of explicit negative material across the six therapy groups.

Some support was obtained for the hypothesis that the Cognitive-behaviour grouping of therapies would contain more implicitly expressed negative material than the Psychodynamic grouping of therapies.

Partial support was obtained for the hypothesis that the Psychoanalytic and Psychodynamic psychotherapy groups would contain a lower level of implicit negative material than the Behaviour, Cognitive-behaviour and Cognitive therapy groups. In fact there was some support for the Psychodynamic group containing a lower level of negative implicit material than the Cognitive group. There was also some support for the Psychoanalytic group containing a lower level than the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Some support was obtained for the hypothesis that the Cognitive-behaviour grouping of therapies would contain more explicit and implicit references combined to negative material than the Psychodynamic grouping. The number of such references were higher in the Cognitive-behaviour grouping than in the Psychodynamic grouping, though the percentage of statements containing such references were higher in the Psychodynamic.

The Cognitive therapy group contained a higher number of explicit and implicit references combined to negative material than the Psychoanalytic psychotherapy group which in turn had a higher percentage of statements containing such references than did the Behaviour therapy group.

7.5 Therapists' Responses to Patients' Negative Material Across Therapies

Results are presented in Table 7.11 of the number of therapist statements in sessions across the two therapy groupings, Cognitive-behaviour and Psychodynamic, which contain each category of potential therapist response to negative patient material about the therapy or therapist. Results are also presented in Table 7.12 of these same categories of potential therapist response analysed across the six therapy groups.

Tables 7.15 and 7.16 detail what percentage of patient statements containing explicit negative comments are followed by a therapist response which is facilitative, what percentage are followed by a restrictive response and what percentage are followed by a therapist statement which does not contain a response to the negative comment. The tables also contains details of therapist response to patients' implicit negative statements and therapist response to explicit and implicit patient negative material combined. Table 7.15 presents results from analysis across the two therapy groupings and Table 7.16 results from analysis across the six therapy groups.

TABLE 7.15. The Percentage of Patient Statements Containing Negative Material Followed by Facilitative, Restrictive and No Response Therapist Categories, Analysed Across the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Therapist Response Category				
Facilitative Response to:				
Explicit	35.93	(19.49)	70.71	(32.06)
Implicit	22.13	(15.79)	72.38	(17.48)
Expl.& Impl.	24.45	(14.72)	70.92	(16.32)
Restrictive Response to:				
Explicit	47.30	(28.34)	6.90	(9.66)
Implicit	43.87	(14.24)	6.95	(10.79)
Expl.& Impl.	44.65	(13.41)	7.00	(9.46)
No Response to:				
Explicit	16.77	(16.64)	23.49	(33.15)
Implicit	34.00	(19.26)	19.91	(17.84)
Expl.& Impl.	30.90	(15.91)	22.08	(16.53)

7.5.1 Therapists' Facilitative Responses

This section of analyses includes testing of the hypotheses that:

i) the Psychodynamic grouping of therapies will have a higher level of therapist facilitative responses to patient explicit negative material than will the Cognitive-behaviour grouping

ii) the Psychodynamic grouping of therapies will have a higher level of therapist facilitative responses to patient implicit negative material than will the Cognitive-behaviour grouping

iii) the Psychodynamic and Psychoanalytic psychotherapy groups will have a higher level of facilitative responses to patient implicit negative material than will the Behaviour, Cognitive-behaviour and Cognitive therapy groups

iv) the Psychodynamic grouping of therapies will have a higher level of therapist facilitative responses to patient combined explicit and implicit negative material than will the Cognitive-behaviour grouping

TABLE 7.16. The Percentage of Patient Statements Containing Negative Material Followed by Facilitative, Restrictive and No Response Therapist Categories, Analysed Across the Six Therapy Groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-behaviour	Conversational		Psychoanalytic	
Therapist Response Category						
Facilitative Response to:						
Explicit	39.29	25.00	39.72	76.61	70.00	50.00
	(15.15)	(35.36)	(16.93)	(16.86)	(47.61)	(9.89)
Implicit	8.18	30.35	27.86	64.78	81.53	70.83
	(10.78)	(14.06)	(14.37)	(21.88)	(3.09)	(20.97)
Expl.& Impl.	11.88	30.65	30.83	63.96	79.63	69.17
	(10.28)	(13.17)	(14.12)	(15.45)	(9.95)	(21.67)
Restrictive Response to:						
Explicit	46.43	50.00	46.39	13.04	2.50	0.00
	(5.05)	(70.71)	(13.89)	(11.49)	(5.00)	(0.00)
Implicit	43.06	43.31	45.23	15.00	5.84	0.00
	(16.11)	(15.74)	(15.23)	(14.97)	(7.07)	(0.00)
Expl.& Impl.	45.31	43.05	45.58	15.28	5.71	0.00
	(12.43)	(16.86)	(14.68)	(11.10)	(6.78)	(0.00)
No Response to:						
Explicit	14.29	25.00	13.89	10.36	30.00	50.00
	(20.20)	(35.36)	(5.77)	(11.97)	(47.61)	(11.29)
Implicit	48.76	26.34	26.91	20.22	10.36	29.17
	(24.37)	(16.23)	(8.22)	(20.38)	(8.68)	(20.97)
Expl.& Impl.	42.81	26.310	23.59	20.76	14.65	30.83
	(17.86)	(16.44)	(7.04)	(14.04)	(12.52)	(21.67)

Facilitative responses to patient explicit negative material

The Two Therapy Groupings and the Six Therapy Groups

An Independent Samples t-Test showed the Psychodynamic grouping to contain a significantly higher percentage of facilitative responses to patients' explicitly expressed negative comments than did the Cognitive-behaviour grouping ($t(22) = 2.658$, $p<0.05$).

Facilitative responses to patient implicit negative material

The Two Therapy Groupings

An Independent Samples t-Test showed the Psychodynamic grouping of therapies to contain a significantly higher percentage of facilitative responses to patients' implicitly expressed negative comments than did the Cognitive-behaviour grouping of therapies ($t(22) = 7.391$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for therapists' facilitative responses to patients' implicit negative material found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 14.003$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of facilitative responses to patients' implicit negative material than did the Behaviour ($t(18) = 6.675$, $p<0.001$), Cognitive-behaviour ($t(18) = 4.658$, $p<0.001$) and Cognitive ($t(18) = 4.884$, $p<0.001$) therapy groups. A series of further a priori contrasts showed the Psychoanalytic psychotherapy group to also contain a higher percentage of facilitative responses than did the Behaviour ($t(18) = 5.702$, $p<0.001$), Cognitive-behaviour ($t(18) = 3.685$, $p<0.005$) and Cognitive ($t(18) = 3.911$, $p<0.01$) therapy groups. Further analyses showed the Conversational psychotherapy group to contain a higher number of such responses than did the Behaviour therapy group (Scheffe test, $p<0.005$).

Facilitative responses to patient explicit and implicit negative material combined

The Two Therapy Groupings

An Independent Samples t-Test showed the Psychodynamic grouping of therapies to contain a significantly higher percentage of facilitative responses to patients' explicit and implicit comments combined than did the Cognitive-behaviour grouping of therapies ($t(22) = 7.324$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for therapists' facilitative responses to patients' explicit and patients' implicit negative material combined found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 13.456$, $p<0.001$). Further analyses showed the Psychodynamic psychotherapy

groups to contain a higher percentage of such responses than did the Behaviour, Cognitive-behaviour and Cognitive therapy groups (Scheffe tests, $p<0.001$, $p<0.001$ and $p<0.001$ respectively). These further analyses also showed the Conversational and Psychoanalytic psychotherapy groups to contain a higher number of such responses than the Behaviour therapy group (Scheffe tests, $p<0.005$ and $p<0.005$ respectively).

No other analyses of therapists' facilitative responses to patients' explicit, implicit, and combined explicit and implicit negative references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Therapists' facilitative responses

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would more often make facilitative responses to patients' explicit negative material than would therapists in the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would more often made facilitative responses to patients' implicit negative material than would therapists in the Cognitive-behaviour grouping of therapies.

Support was obtained for the hypothesis that therapists in the Psychodynamic psychotherapy group would more often make facilitative responses to patients' implicit negative material than would therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Support was obtained for the hypothesis that therapists in the Psychoanalytic psychotherapy group would more often make facilitative responses to patients' implicit negative material than would therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Therapists in the Conversational psychotherapy group more often made facilitative responses to patients' implicit negative material than did therapists in the Behaviour therapy group.

Support was obtained for the hypothesis that therapists in the Psychodynamic grouping of therapies would more often make facilitative responses to patients' explicit and implicit combined negative material than would therapists in the Cognitive-behaviour grouping of therapies.

Therapists in the Psychodynamic psychotherapy group more often made facilitative responses to patients' explicit and implicit combined negative material than did therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups.

Therapists in the Conversational and Psychoanalytic psychotherapy groups more often made facilitative responses to patients' explicit and implicit combined negative material than did therapists in the Behaviour therapy group.

7.5.2 Therapists' Restrictive Responses

This section of analyses includes testing of the hypotheses that:

i) the Cognitive-behaviour grouping of therapies will have a higher rate of therapist restrictive responses to patient explicit negative material than will the Psychodynamic grouping

ii) the Cognitive-behaviour grouping of therapies will have a higher rate of therapist restrictive responses to patient implicit negative material than will the Psychodynamic grouping

iii) the Behaviour, Cognitive-behaviour and Cognitive therapy groups will have a higher rate of therapist restrictive responses to patient implicit negative material than will the Psychodynamic and Psychoanalytic psychotherapy groups

iv) the Cognitive-behaviour grouping of therapies will have a higher rate of therapist restrictive responses to patient combined explicit and implicit negative material than will the Psychodynamic grouping

v) the Behaviour, Cognitive-behaviour and Cognitive therapy groups will have a higher rate of therapist restrictive responses to patient combined explicit and implicit negative material than will the Psychodynamic and Psychoanalytic psychotherapy groups

Restrictive responses to patient explicit negative material

The Two Therapy Groupings and The Six Therapy Groups

An Independent Samples t-Test showed the Cognitive-behaviour grouping of therapies to contain a significantly higher percentage of restrictive responses to patients' explicitly expressed negative comments than did the Psychodynamic grouping of therapies ($t(22) = 4.034$, $p<0.001$).

Restrictive responses to patient implicit negative material

The Two Therapy Groupings

An Independent Samples t-Test showed the Cognitive-behaviour grouping of therapies to contain a significantly higher percentage of restrictive responses to patients' implicitly expressed negative comments than did the Psychodynamic grouping of therapies ($t(22) = 7.160$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for therapists' restrictive responses to patients' implicit negative material found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 10.238$, $p<0.001$). A priori contrasts showed the Behaviour, Cognitive-behaviour and Cognitive therapy groups to contain a higher percentage of restrictive responses to patients' implicit negative material than did the Psychodynamic psychotherapy group ($t(18) = 4.049$, $p<0.01$; $t(18) = 4.077$, $p<0.001$; and $t(18) = 4.286$, $p<0.001$ respectively). A series of further a priori contrasts also showed the Behaviour, Cognitive-behaviour and Cognitive therapy groups to contain a higher percentage of restrictive responses than did the Psychoanalytic psychotherapy group ($t(18) = 4.685$, $p<0.001$; $t(18) = 4.713$, $p<0.001$; and $t(18) = 4.922$, $p<0.001$).

Restrictive responses to patient explicit and implicit negative material combined

The Two Therapy Groupings

An Independent Samples t-Test showed the Cognitive-behaviour grouping of therapies to contain a significantly higher percentage of restrictive responses to patients' explicit and implicit comments combined than did the Psychodynamic grouping of therapies ($t(22) = 7.947$, $p<0.001$).

The Six Therapy Groups

A one-way ANOVA for therapists' restrictive responses to patients' explicit and patients' implicit negative material combined found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 13.112$, $p<0.001$). A priori contrasts showed the Behaviour, Cognitive-behaviour and Cognitive therapy groups to contain a higher percentage of restrictive responses to patients' explicit and implicit negative material combined than did the Psychodynamic psychotherapy group ($t(18) = 4.780$, $p<0.001$; $t(18) = 4.507$, $p<0.001$; and $t(18) = 4.813$, $p<0.001$ respectively). A series of further a priori contrasts also showed the Behaviour, Cognitive-behaviour and Cognitive therapy groups to contain a higher percentage of restrictive responses than did the Psychoanalytic psychotherapy group ($t(18) = 5.470$, $p<0.001$; $t(18) = 5.197$, $p<0.001$; and $t(18) = 5.503$, $p<0.001$).

No other analyses of therapists' restrictive responses to patients' explicit, implicit, and combined explicit and implicit negative references showed any significant differences either across the two therapy groupings or the six therapy groups.

Summary

Therapists' restrictive responses

Support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would more often make restrictive responses to patients' explicit negative material than would therapists in the Psychodynamic grouping of therapies.

Support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would more often make restrictive responses to patients' implicit negative material than would therapists in the Psychodynamic grouping of therapies.

Support was obtained for the hypothesis that therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups would more often make restrictive responses to patients' implicit negative material than would therapists in the Psychodynamic and Psychoanalytic psychotherapy groups.

Support was obtained for the hypothesis that therapists in the Cognitive-behaviour grouping of therapies would more often make restrictive responses to patients' explicit and implicit combined negative material than would therapists in the Psychodynamic grouping of therapies.

Support was obtained for the hypothesis that therapists in the Behaviour, Cognitive-behaviour and Cognitive therapy groups would more often make restrictive responses to patients' explicit and implicit combined negative material than would therapists in the Psychodynamic and Psychoanalytic psychotherapy groups.

7.5.3 Therapists' No Responses

This section of analyses tests the hypothesis that there will be no difference in therapist 'no responses' to patient negative material either across the Cognitive-behaviour and Psychodynamic therapy groupings or across the six therapy groups

No responses to patient explicit, implicit, and explicit and implicit combined negative material

The Two Therapy Groupings

Independent Samples t-Tests showed there to be no significant difference between the Cognitive-behaviour and Psychodynamic grouping of therapies with respect to therapist "no responses" to patients' explicit, implicit and explicit and implicit combined negative comments.

The Six Therapy Groups

A series of one-way ANOVA for therapists' "no responses" to patients' explicit, implicit and explicit and implicit combined negative material did not show any significant effects of type of therapy across the six therapy groups.

Summary

Therapists 'no responses'

Support was obtained for the hypothesis that there would be no difference both between the two therapy groupings and between the six therapy groups in therapists' 'no responses' to patients' explicit, implicit and combined explicit and implicit references to negative material.

7.5.4 The Mean Therapist Response

This section of analyses includes testing of the hypothesis that the Psychodynamic grouping of therapies will have a higher, facilitative, mean therapist response rating than the Cognitive-behaviour grouping's lower, restrictive, mean rating.

The mean point on the *Therapist Response (Facilitative-Restrictive) Rating Scale* of therapists' responses to negative patient material was analysed across the two therapy groupings and across the six therapy groups. The results of this analysis are shown in Table 7.17.

The Two Therapy Groupings

An Independent Samples t-Test was used to compare, across the Cognitive-behaviour and Psychodynamic grouping of therapies, the mean point on the *Therapist Response (Facilitative-Restrictive) Rating Scale* of therapists' responses to negative patient material. The test showed the Psychodynamic grouping of therapies to have a significantly higher, more facilitative, mean rating than did the Cognitive-behaviour grouping of therapies ($t(22) = 10.867$, $p<0.001$).

Table 7.17. The Mean Rating of Therapists' Responses to Negative Patient Material Analysed Across the Six Therapy Groups and the Two Therapy Groupings (standard deviation in brackets)

Group	Mean	Standard Deviation
Behaviour	-0.698	(0.398)
Cognitive-behaviour	-0.278	(0.291)
Cognitive	-0.390	(0.317)
Conversational	1.088	(0.289)
Psychodynamic	1.368	(0.412)
Psychoanalytic	1.733	(0.524)
CBT Grouping	-0.455	(0.358)
PD Grouping	1.396	(0.469)

The Six Therapy Groups

A one-way ANOVA for the mean rating point on the *Therapist response (Facilitative-Restrictive) Rating Scale* of therapists' responses to patients' negative material found a significant effect of type of therapy across the six therapy groups ($F(5, 18) = 29.982$, $p<0.001$). Further analyses showed the Conversational psychotherapy group to have a significantly higher, more facilitative, mean rating point than did the Behaviour, Cognitive-behaviour and Cognitive therapy groups (Scheffe tests, $p<0.001$, $p<0.005$ and $p<0.005$ respectively). These further analyses also showed the Psychodynamic group to have a significantly higher, more facilitative, mean rating point than the Behaviour, Cognitive-behaviour and Cognitive therapy groups (Scheffe tests, $p<0.001$, $p<0.001$ and $p<0.001$ respectively) and the Psychoanalytic group too to have a significantly higher, more facilitative, mean rating point than the Behaviour, Cognitive-behaviour and Cognitive therapy groups (Scheffe tests, $p<0.001$, $p<0.001$ and $p<0.001$ respectively).

Summary

Mean therapist response

Support was obtained for the hypothesis that the Psychodynamic grouping of therapies would have a higher, and facilitative, mean therapist response rating than the Cognitive-behaviour grouping which would have a lower, and restrictive, mean therapist response rating.

The Conversational, Psychodynamic and Psychoanalytic psychotherapy groups all had higher, facilitative, mean therapist response ratings than the Behaviour, Cognitive-behaviour and Cognitive therapy groups which all had restrictive mean therapist response ratings.

7.6 Patients' Expressed Negative Material Across Early and Late Sessions and by Type of Therapy

This section of analyses includes testing of the hypothesis that patients' implicitly made negative references about the therapy or therapist would be higher in late sessions of the Cognitive-behaviour grouping of therapies than in early sessions.

Results are presented of the number of patient statements in early and in late sessions containing negative comment about the therapy or therapist and the rate of such comments.

Results of the number of patient statements in sessions containing negative comments analysed across the two therapy groupings, Cognitive-behaviour therapies and Psychodynamic psychotherapies, and across early and late sessions are detailed in Table 7.18. Categorised therapists' responses to these negative comments are presented in Table 7.19. Results of analyses, across early and late sessions, of the rate of negative comments across the two therapy groupings are presented in Table 7.20.

Table 7.18. The Number of Patient Statements Containing Negative Comments Across the Two Therapy Groupings and Across Early and Late Sessions (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient Category				
Explicit (E)	5.83	(5.91)	5.17	(5.60)
Explicit (L)	3.50	(4.72)	3.33	(4.46)
Implicit (E)	22.33	(10.80)	8.33	(5.92)
Implicit (L)	25.83	(16.56)	11.33	(6.41)
Expl.& Impl. (E)	28.17	(15.14)	13.50	(11.22)
Expl.& Impl. (L)	29.33	(19.92)	14.67	(10.27)

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the two therapy groupings with respect to the

number of patient statements in sessions containing negative material expressed explicitly, implicitly, and explicitly and implicitly combined, and the rate of such references. These two-way repeated measures ANOVAs did not show a significant effect of session order or of the interaction of session order and type of therapy on any of these variables.

Paired samples t-Tests compared these same variables across early and late sessions of each of the two therapy groupings and found no significant effect of session order.

Independent samples t-Tests compared the same variables across early sessions of the two therapy groupings and across late sessions of the two groupings and found no significant effect of session order.

Table 7.19. The Number of Therapist Statements Containing Each Category of Response to Patient Statements Containing Negative Comments Across the Two Therapy Groups and Across Early and Late Sessions (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient/therapist Category				
Therapist Facilitative response to:				
Explicit (E)	2.17	(2.64)	3.67	(4.32)
Explicit (L)	1.50	(2.35)	2.67	(3.44)
Implicit (E)	6.33	(4.46)	6.67	(5.35)
Implicit (L)	6.50	(10.17)	7.67	(4.97)
Expl.& Impl. (E)	8.50	(6.09)	10.33	(9.52)
Expl.& Impl. (L)	8.00	(12.43)	10.33	(7.97)
Therapist Restrictive response to:				
Explicit (E)	2.83	(2.64)	0.50	(0.55)
Explicit (L)	1.33	(2.16)	0.33	(0.82)
Implicit (E)	10.17	(5.85)	0.33	(0.52)
Implicit (L)	10.33	(4.08)	1.83	((2.71)
Expl.& Impl. (E)	13.00	(7.64)	0.83	(0.98)
Expl.& Impl. (L)	11.67	(5.16)	2.17	(3.49)
Therapist No Response to:				
Explicit (E)	0.83	(0.98)	1.17	(1.17)
Explicit (L)	0.67	(0.82)	0.33	(0.82)
Implicit (E)	5.83	(3.49)	1.17	(1.47)
Implicit (L)	9.00	(4.86)	1.83	(1.72)
Expl.& Impl. (E)	6.67	(4.27)	2.33	(1.51)
Expl.& Impl (L)	9.67	(5.01)	2.17	(1.47)

Table 7.20. The Rate of Negative Comments in Patient Statements Across the Two Therapy Groupings and Across Early and Late Sessions (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient Category				
Explicit (E)	0.02	(0.02)	0.02	(0.02)
Explicit (L)	0.01	(0.02)	0.02	(0.02)
Implicit (E)	0.06	(0.04)	0.09	(0.10)
Implicit (L)	0.09	(0.03)	0.08	(0.03)
Expl.& Impl. (E)	0.06	(0.04)	0.09	(0.10)
Expl.& Impl. (L)	0.09	(0.03)	0.08	(0.03)

Summary

Patient negative material across early and late sessions

Support was not obtained for the hypothesis that patients' implicitly made negative references about the therapy or therapist would be higher in late sessions of the Cognitive-behaviour therapy grouping than in early sessions.

There was no significant effect of session order or of the interaction of session order and type of therapy on patients' explicit, implicit, or combined explicit and implicit negative material either across the two therapy groupings or across the six therapy groups.

7.7 Therapists' Responses to Patients' Negative Material Across Early and Late Sessions and by Type of Therapy

Results are presented of therapists' responses to patient statements in early and in late sessions containing negative comment about the therapy or therapist.

Table 7.19 details, for the two therapy groupings, the mean number of therapist statements in a session which contain each category of potential therapist response to negative patient material.

Tables 7.21 details, for the two therapy groupings, what percentage of patient statements containing explicit negative comments are followed by a therapist response which is facilitative, what percentage are followed by a restrictive response and what percentage are followed by a therapist statement which does not contain a response to the negative comment. The table also

contains details of therapist response to patients' implicit negative statements and therapist response to explicit and implicit patient negative material combined.

TABLE 7.21. The Percentage of Patient Statements Containing Negative Material That Are Followed by Facilitative, Restrictive and No Response Therapist Categories, Analysed Across the Two Therapy Groupings and Early and Late Sessions (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Therapist Response Category				
Facilitative Response to:				
Explicit (E)	31.05	(19.84)	55.29	(32.96)
Explicit (L)	44.07	(19.57)	90.00	(20.00)
Implicit (E)	26.00	(16.45)	80.16	(15.81)
Implicit (L)	18.26	(15.55)	64.60	(16.64)
Expl.& Impl. (E)	29.52	(12.28)	75.67	(15.41)
Expl.& Impl. (L)	19.38	(16.26)	66.18	(17.17)
Restrictive Response to:				
Explicit (E)	58.57	(24.41)	8.43	(10.26)
Explicit (L)	28.52	(27.81)	5.00	(10.00)
Implicit (E)	42.88	(16.62)	2.90	(4.51)
Implicit (L)	44.85	(12.93)	10.99	(14.01)
Expl.& Impl. (E)	44.47	(14.49)	4.21	(5.50)
Expl.& Impl. (L)	44.82	(13.63)	9.79	(12.16)
No Response to:				
Explicit (E)	10.38	(11.78)	38.29	(38.83)
Explicit (L)	27.41	(20.50)	5.00	(10.00)
Implicit (E)	31.12	(24.18)	20.13	(15.25)
Implicit (L)	36.89	(14.56)	24.40	(20.14)
Expl.& Impl. (E)	26.01	(16.49)	20.13	(15.25)
Expl.& Impl. (L)	35.79	(15.08)	24.04	(18.95)

A two-way repeated measures ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the Cognitive-behaviour grouping of therapies and the Psychodynamic grouping of therapies with respect to therapist response to patients' explicit negative comments, their implicit negative comments, and to their explicit and implicit negative material combined. The analysis showed no significant effect of session order or of the interaction of session order and type of therapy on any category of therapist response. There were however significant effects of type of therapy on therapists' responses which replicated findings from independent samples t-Tests reported above (see pages 292-297).

A paired samples t-Test compared therapist response to patients' explicit negative comments, their implicit negative comments, and to their explicit and implicit negative material combined across early and late sessions of each of the two therapy groupings and found no significant effect of session order.

Summary

Therapist response across early and late sessions

There was no significant effect of session order or of the interaction of session order and type of therapy either across the two therapy groupings on therapists':

i) facilitative responses to patient explicit negative material
ii) facilitative responses to patient implicit negative material
iii) facilitative responses to patient explicit and implicit combined negative material
iv) restrictive responses to patient explicit negative material
v) restrictive responses to patient implicit negative material
vi) restrictive responses to patient explicit and implicit combined negative material.
vii) no response to patient explicit negative material
viii) no response to patient implicit negative material
ix) no response to patient explicit and implicit combined negative material.

7.8 The Mean Therapist Response Across Early and Late Sessions

The mean point on the *Therapist Response (Facilitative-Restrictive) Rating Scale* of therapists' responses to negative patient material across early and late sessions of therapy was analysed across the two therapy groupings. The results of this analysis are shown in Table 7.22.

A two-way repeated measures ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the Cognitive-behaviour grouping of therapies and the Psychodynamic grouping of therapies across early and late sessions with respect to the mean point on the *Therapist Response (Facilitative-Restrictive) Rating Scale* of therapists' responses to negative patient material. The analysis showed no significant effect of session order or of the interaction of session order and type of therapy on the mean point of therapists'

responses. There was however a significant effect of type of therapy which replicated earlier findings from an independent samples t-Test (see page 297).

Table 7.22. The Mean Rating of Therapists' Responses to Negative Patient Material Analysed Across the Two Therapy Groupings and Across Early and Late Sessions (standard deviation in brackets)

Grouping	Mean	Standard Deviation
CBT Grouping (E)	-0.333	(0.300)
CBT Grouping (L)	-0.577	(0.395)
PD Grouping (E)	1.502	(0.598)
PD Grouping (L)	1.290	(0.315)

A paired samples t-Test compared the mean therapist response across early and late sessions of each of the two therapy groupings and found no significant effect of session order.

Summary

Mean therapist response

There was no significant effect of session order or of the interaction of session order and type of therapy on the mean therapist response rating across the two therapy.

7.9 RESULTS SUMMARY - THERAPISTS' RESPONSE TO PATIENTS' NEGATIVE MATERIAL

The results of the analyses of patient negative material about therapy and the therapist and about therapists' response to it which have been detailed in this chapter are summarised in the tables beneath. The summaries itemise whether or not each of the various comparisons analysed showed a significant difference across the two therapy groupings and across the six therapy groups.

Table 7.23 presents a summary of comparisons of patient negative material about therapy and the therapist where the main effect analysed was type of therapy. Table 7.24 summarises comparisons of therapist response to patient negative material also across type of therapy.

Table 7.25 presents a summary of comparisons of patient negative material where the main effect analysed was the interaction of session order and type of therapy. Finally, Table 7.26 summarises the effect of the interaction of session order and type of therapy on therapist response to patient negative material.

Table 7.23. Summary of Results of Comparisons Across Type of Therapy of Patient Negative Material

	Two Therapy Groupings				Six Therapy Groups			
Reference	No.	Percent.	Mean	Rate	No.	Percent.	Mean	Rate
Explicit	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Implicit	Sig.	N.S.	N.S.	N.S.	Sig.	Sig.	Sig.	N.S.
Expl.& Impl.	Sig.	Sig.	N.S.	N.S.	Sig.	Sig.	N.S.	N.S.

Table 7.24. Summary of Results of Comparisons Across Type of Therapy of Therapist Response to Patient Negative Material

	Two Therapy Groupings			Six Therapy Groups		
Reference	Expl.	Impl.	Expl.&Impl.	Expl.	Impl.	Expl.&Impl.
Facilitative	Sig.	Sig.	Sig.	N.S.	Sig.	Sig.
Restrictive	Sig.	Sig.	Sig.	N.S.	Sig.	Sig.
No Response	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.

Table 7.25. Summary of Results of the Effect of the Interaction of Session Order and Type of Therapy on Patient Negative Material

	Two Therapy Groupings			
Reference	No.	Percent.	Mean	Rate
Explicit	N.S.	N.S.	N.S.	N.S.
Implicit	N.S.	N.S.	N.S.	N.S.
Explicit & Implicit	N.S.	N.S.	N.S.	N.S.

Table 7.26. Summary of Results of the Effect of the Interaction of Session Order and Type of Therapy on Therapist Response to Patient Negative Material

	Two Therapy Groupings		
Reference	Explicit	Implicit	Expl.&Impl.
Facilitative	N.S.	N.S.	N.S.
Restrictive	N.S.	N.S.	N.S.
No Response	N.S.	N.S.	N.S.

7.10 DISCUSSION

7.10.1 Patients' Negative Material

The analysis of patients' negative material about the therapy or therapist, and therapist response to it, was much as predicted. There was no significant difference either between the two therapy groupings or the six therapy groups in the occurrence of patients' explicitly expressed negative material. There was some evidence of the psychodynamic grouping of therapies containing a lower number of patient implicit negative references overall than the cognitive-behaviour grouping, with the psychoanalytic psychotherapy group containing a lower number than the behaviour, cognitive-behaviour and cognitive therapy groups and the psychodynamic a lower number than the cognitive. The number of implicit negative comments increased in late over early sessions of the behaviour therapy and cognitive therapy groups. The small sample sizes in each condition means this finding must be viewed with caution. But it is of note that these two groups also had the most restrictive therapist response of all the groups. The possibility is therefore raised that patients' negative material about the therapy or therapist, indicative of ruptures in the therapeutic alliance, was not adequately addressed in early sessions of these groups and that as a result implicit expression of negative material increased. Increasingly cognitive therapies are recognising the importance of addressing such alliance ruptures and the therapeutic potential within them (cf. Padesky, 2000).

Although the psychodynamic grouping had a higher percentage of statements containing explicit and implicit references combined this is not suprising given the long length of patient statements in these therapies which thereby greatly increased the likelihood of them containing a negative comment.

7.10.2 Therapists' Response to Patients' Negative Material

The data analyses presented in Chapter Five showed therapists in the psychodynamic grouping of therapies to focus more than did cognitive-behaviour therapists on the transferential patient-therapist relationship and on implicit material within it. It might therefore to be expected that psychodynamic psychotherapists would more often, as they did, make facilitative responses to patient negative comments; be they transferential or non-transferential and be they expressed explicitly, implicitly or explicitly and implicitly combined, than cognitive-behaviour therapists.

In comparing the six therapy groups, therapists in the psychodynamic and psychoanalytic psychotherapy groups, also as expected, more often made facilitative responses to patients' implicitly expressed negative material than did therapists in the behaviour, cognitive-behaviour and cognitive therapy groups.

Therapists in the cognitive-behaviour grouping of therapies more often made restrictive responses to patients' negative comments, be they expressed explicitly, implicitly, or explicitly and implicitly combined, than did therapists in the psychodynamic grouping of therapies. In comparing the six therapy groups, therapists in the behaviour, cognitive-behaviour, and cognitive therapy groups more often made restrictive responses to patients' negative comments, be they expressed implicitly or explicitly and implicitly combined, than did therapists in the psychodynamic and the psychoanalytic psychotherapy groups.

Each of the cognitive-behaviour therapies had a restrictive mean therapist response and each of the psychodynamic a facilitative. Does this matter, that therapists in cognitive-behaviour therapies, and also, to a degree, in conversational psychotherapy, do not tend to facilitate the expression and resolution of patients' negative material about therapy and the therapist ? As noted above, there are certainly potential benefits to attending to negative material in the patient-therapist relationship and cognitive therapies are increasingly recognising this. Many mental health problems have unresolved relationship issues and problems in interpersonal relating at their core. Many current difficulties express themselves in current day relationships and are derived from early life relationships. These difficulties are shown to us in the consulting room, we can see illness in action, understand the patient more deeply, and ameliorate these difficulties by attending to the patient-therapist relationship in its transferential and its broader aspects. As Whiteley and Gordon (1979) put it in writing of group psychotherapy, "if mental illness is viewed as a disorder of interpersonal functioning, it may be more clearly understood and remedied through exploration, insight and readjustment in the group interpersonal context that gave rise to it in the first place.." (p.12). But additionally, the quality of the therapeutic alliance is a major determinant of outcome,

over and above the issue of premature termination. Thus, for example, Krupnick et al (1996) analysing data from the National Institute of Mental Health comparative trial of therapies for depression found that the therapeutic alliance accounted for 21% of the variance in Beck Depression Inventory and Hamilton Rating Scale of Depression scores.

As noted above, Gill (1979) distinguishes between patients' resistance to the awareness of transference and their resistance to its resolution. He argued that resistance to the awareness of transference on the part of patients is often due to difficulties in recognising erotic or hostile impulses toward therapists; also because the attitudes patients believe therapists have toward them are often the ones patients are least likely to voice, thinking it would be impertinent to do so and because patients believe therapists will not like what is ascribed to them. Such views are therefore most often expressed implicitly and the therapist is often reluctant to identify them.

Some therapists may fail to recognise patients' implicit negative feelings. Others may be cautious about addressing them, seeing them as at best irrelevant and at worse potentially damaging. Thus they "nip them off at the bud" immediately preventing their exploration and easing the tension between the patient and therapist or within the therapist. Indeed, Freud's view of transference varied in this regard throughout his working life. Bird (1972) notes "..an on-and-off tendency to regard transference merely as a technical matter, often writing of it as an asset to analysis when positive and a liability when negative." (p.274).

In *Analysis Terminable and Interminable* (1937) Freud, in referring to a rebuke from Ferenczi that negative transference should be analysed, cautions against stirring up pathogenic conflict. This apparent questioning of the pursuit of negative transference and Bird's observation about Freud's view of it seem in marked contrast to his statement "In psycho-analysis ... all the patient's tendencies, including hostile ones, are aroused; they are then turned to account for the purposes of the analysis by being made conscious, and in this way the transference is constantly being destroyed..... Transference, which seems ordained to be the greatest obstacle to psychoanalysis, becomes its most powerful ally, if its presence can be detected each time and explained to the patient" (Freud, 1905, p.159).

CHAPTER 8

DISCUSSION

8.1 Summary

References to all the transference components were made by patients and by therapists in all six therapy groups, but as expected the level of these references was lower in the cognitive-behaviour therapies than in the psychodynamic psychotherapies. Patients in both the cognitive-behaviour and the psychodynamic groupings of therapies made statements explicitly linking all five transference components as well as linking them by a combination of explicit and implicit references. Again, as expected, the level of this linking was lower in the cognitive-behaviour grouping than in the psychodynamic grouping and analyses across the six therapy groups also showed that patients in the behaviour therapy group did not link together more than three transference components within a statement. As well as making significantly less links of transference components than psychodynamic psychotherapists, therapists in the cognitive-behaviour grouping of therapies also made less links than their patients. They rarely linked together more than two transference components (particularly therapists in the behaviour therapy and cognitive-behaviour therapy groups), rarely explored patients' explicitly expressed thoughts and feelings about the therapy or therapist (or those implicitly expressed), and were restrictive rather than facilitative in response when these feelings were negative. By contrast psychodynamic psychotherapists commonly explored the transferential patient-therapist relationship and addressed patients' negative feelings about the therapy and therapist.

It had been proposed that patients' explicit references to transference components generally would tend not be facilitated by cognitive-behaviour therapists, that they would therefore find expression implicitly and as a result there would be comparable levels of implicit references across therapies. But implicit patient references to individual components, as well as explicit, and as well as summated scores, were higher in the psychodynamic grouping of therapies. This suggests, as was discussed in Chapter Five, that psychodynamic psychotherapies succeed in their intent to create a therapeutic environment which encourages the expression and exploration of patients' internal worlds and the transferential relationships derived from them and, in so doing, encourage and intensify implicit as well as explicit transference references. Although generally implicit references

to transference components were higher in the psychodynamic psychotherapies than the cognitive-behaviour therapies, the relative levels of explicit and implicit references within, as opposed to across, groupings was of note. Thus, for example, the number of implicit references about the therapist made by patients in the cognitive-behaviour grouping of therapies was markedly higher than their implicit references to other components, and also markedly higher than their explicit references about the therapist. In addition, although the rate of patient explicitly expressed negative material about the therapist or therapy was comparable across early sessions of the two therapy groupings in late therapy sessions the picture was different. By then, in the cognitive-behaviour grouping these explicit references had reduced by 50%, as had linking of them, and implicit references increased by 50% whereas in the psychodynamic grouping the level of explicit references had stayed the same and implicit references had reduced by 50%. Therapists in the psychodynamic grouping of therapies facilitated exploration of the patient-therapist relationship including patients' negative feelings about it. Conversely, cognitive-behaviour therapists, as reported above, rarely picked up patients' explicitly and implicitly expressed feelings about them and therapy. Indeed, this study shows they were restrictive in their responses when such feelings were negative, whereas psychodynamic psychotherapists were facilitative. The possibility is therefore raised that patients frequently made such comments covertly (though not necessarily unconsciously). Certainly the two therapy groups with the most restrictive therapist responses (the behaviour therapy and the cognitive therapy) saw the biggest increase in patient implicit references to negative material in late over early sessions. Therapists in cognitive-behaviour therapies could beneficially attend to such ruptures in the patient-therapist relationship (and some now are e.g. Linehan, 1993; Padesky, 2000; Safran, 1998; and Young and Lindemann, 1992) and through this enhance the therapeutic alliance. They could also, through focusing on the transferential patient-therapist relationship, gain further insight into the patient's intrapersonal and interpersonal worlds and bring about positive change in them.

As expected, therapists in the psychodynamic grouping of therapies focused more on parents and past feelings and more on past and in-session time frames than did therapists in the cognitive-behaviour grouping. They also, and this was unexpected given the central focus on patients' thoughts in cognitive-behaviour theory and technique, focused more on patients' thoughts. Further analyses across the six therapy groups showed therapists in the psychodynamic psychotherapy group focused more on parents, past feelings and thoughts, and more on the past time frame, than did therapists in the psychoanalytic psychotherapy group, and that they made more links between past feelings and parents and current feelings and therapist. These findings, though needing to be interpreted with caution because of the small number of therapists in the sample, suggest a diachronistic emphasis with genetic reconstruction in psychodynamic psychotherapy contrasted

with a synchronistic emphasis in psychoanalytic psychotherapy with in-session transference interpretation elucidating the patients' current internal world. It was argued in Chapter One that such intrapersonal focus is typical of psychodynamic psychotherapies and contrary to the commonly expressed view (e.g. Goldsamt et al, 1992; Kerr et al, 1992) that the focus of cognitive-behaviour therapies is primarily intrapersonal and the focus of psychodynamic psychotherapies is primarily interpersonal. Support was obtained in this study for the contention that psychodynamic psychotherapies do have an intrapersonal focus. Both therapy groupings focused more on intrapersonal links than interpersonal and the psychodynamic grouping had higher levels of focus on both.

8.2 Some Common Ground Between Therapies?

Psychodynamic psychotherapists' technique draws on theory of the internal world of patients: representations of relationships which express relational wishes, needs, expectations, conflicts, fears and defensive adaptations. With respect to defensive adaptations Brewin (1997) expresses his surprise that cognitive therapy for anxiety and depression has not addressed explicitly the issue of psychological defences and their role in the treatment process. He concludes that "it seems likely that the next decade will lead to a much greater appreciation of the mechanisms underlying psychological defences and to their incorporation within mainstream cognitive therapy." (p.119). Power (1997) challenges the central view of cognitive therapy that negative emotions are generated through negative automatic thoughts (NATs) and that challenging these thoughts will ameliorate them. His Schematic, Propositional, Associative, and Analogical Representation Systems (SPAARS) model (Power and Dalgleish, 1997), which incorporates psychoanalytic conceptions of the unconscious, explains that:

> many emotions do not involve NATs in their generation. Chasing NATs in cognitive therapy may sometimes be a fruitless task, because there are no NATs to be caught ! Moreover, we believe that our patients have been telling us this fact for a long time when they report that they had no thoughts in a particular situation, that the emotion came over them 'out of the blue'. The practice of cognitive therapy needs therefore to be altered.....(p.71).

But it is not just with defences that psychoanalytic thinking may inform cognitive-behaviour therapy but on the broader levels of transference and of the patient-therapist relationship and the treatment process and it is here this thesis has researched. Though limited, there are those within cognitive-behaviour therapy, such as Linehan (1993), who have written about how patients' use of therapy may both impede and inform the therapeutic process. She, as discussed in Chapter One, found that the problems of many patients she saw for cognitive-behaviour therapy did not appear

to result primarily from cognitive distortion, that often she could not keep them in treatment, and that she thought them invalidated by being told their thinking was irrational. Brewin, Smith, Power and Furnham (1992) posited that depressed peoples' thinking is not illogical and Teasdale (1997) that rational argument is frequently ineffectual in changing emotional response. Beck has even cautioned there is no proof of cognitive therapy having long term benefits in preventing relapse in depressed patients (Hollon and Beck, 1994). In Chapter One it was noted that in addressing these and other issues some prominent cognitive-behaviour practitioners, including Linehan (1993) with Dialectical Behaviour therapy, have embraced psychoanalytic concepts. It was also noted that in some areas the gap between cognitive-behaviour and psychoanalytic thinking is not large, for example the similarity between the deep schemas conceptualised by cognitive therapists (cf. Guidano and Liotti, 1983; Young,1994) and the psychodynamic conceptualisation of internal object relations, see for example Bowlby (1988) or Nunberg (1951):

> The transference proceeds according to the need to assimilate actual experiences in such a way that their perception either conforms to or becomes identical with repressed unconscious ideas. What has once been experienced - particularly in childhood - seems to form an indelible imprint in the unconscious from which patterns develop. These patterns may be dormant for a long time and become active only under certain circumstances..... In the transference situation the unconscious pattern overshadows the conscious perception of an actual event (p.5).

Psychodynamic models such as Malan's (1979), and Luborsky's Core Conflictual Relationship Theme (Luborsky and Crits-Christoph, 1990), overlap with some cognitive models, and their simplification of psychoanalytic theory and technique have more readily lent them to empirical research. In addition there are cognitive reformulations of aspects of psychoanalytic theories (e.g. Horowitz, 1988), in particular of the unconscious (Power and Brewin, 1991) and of transference (Mallinger, 1974).

These cognitive reformulations of aspects of psychoanalytic theorising reflect moves that have occurred not just in cognitive theorising but in psychoanalytic theorising too. Weston (1991) notes that:

> since the 1940s, psychodynamic theory and therapy has shifted toward a greater emphasis on patterns of thought and feeling that underlie interpersonal behaviour. With this change in emphasis (primarily away from a psychology of drives) have emerged object relations theories, which focus on the nature and development of mental representations of the self and others (the person's *representational world*; Sandler and Rosenblatt, 1962). (p.429)

This is a shift that has seen the similarity between the deep schemas of cognitive theory and the internal object relations of psychodynamic theory referred to above. Transference has evolved in the 20th Century from its inception in the instinctual and economic context of libido theory. Its conception as an instinctually rooted compulsion to repeat has long been questioned (Kubie, 1939) and today it is predominantly seen as the unconscious enactment of internal object relations (or the *mental representations of self and others* that Weston refers to) which are based on the experience of key relationships in childhood. It has also evolved from being generally seen as an artefact of pathology and the analytic consulting room to something mediating all relationships. Both are viewpoints which more readily allow for its affiliation with cognitive-behaviour therapies. For example, one leading psychoanalytic scholar Meissner (1991) in considering "how does analysis work ?" embraces Weiss and Sampson's (1986) view that what changes in therapy are unconscious and pathogenic belief systems, derived from traumatic experiences, often in childhood, and which in psychoanalysis are brought into focus in the transference.

This evolution of transference has along the way touched theoretical issues that remain potentially pertinent not just to psychoanalytic therapists but to those of other orientations. For example, Freud's (1895) first reference to transference: 'transference on to the physician takes place through a false connection....' (p.390) notes how an emotion related to unconscious memory may become consciously experienced in the consulting room. Transference was thus regarded as a displacement of affect and much store laid by catharsis as an ameliorative process. In fact it is much more than displacement of affect. But what can be helpfully exported here is the view that patients' interactions with therapists may tell us something about their earlier relationships, and indeed about their current relationships too.

Over time this view led to the conviction that patients cannot remember all that is unconscious but will enact it within the relationship with the therapist. Commonly referred to as repetition compulsion (cf. Freud, 1920), exploring and gaining insight into the unconscious conflict expressed in this enactment would lead to its amelioration "... a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broke." (Freud, 1909, p.280). Whilst Anna Freud's (1936) view of transference was essentially a traditional one:

> all those impulses experienced by the patient in his relation with the analyst which are not newly created by the objective analytic situation but have their source in early - indeed, the very earliest relations and are now merely revived under the influence of the repetition compulsion ..... these impulses are repetitions and not new creations. (p.18)

she importantly broadened the understanding of transference to one of defence as well as of repetition or displacement of earlier relationships. She thus was moving transference closer to a current psychoanalytic view that patients' interactions with therapists may tell us something about their internal worlds, pervasive structures derived from significant early relationships and which structure our experience of current relationships with others and with ourselves. At a similar time Horney (1939) was arguing there was no clear basis from which to insist that the tendency to repeat previous experiences was derived from instincts as opposed to the personality structure of individuals requiring new experiences to be integrated within them. This conception of transference is of utility to some cognitive-behaviour therapists and a gateway to further psychoanalytic theorising and technique. It is also a gateway through which some psychoanalytic therapists pass to consider cognitive theory.

A passing remark by Freud (1925) in *Observations on Transference Love*, that the analyst "must recognise that the patient's falling in love is induced by the analytic situation..." (p.379) offers the possibility that he might have considered the therapist's presentation could fashion the patient's transference. But it was unclear what importance he attached to this comment against his traditional view that regardless of the nature of the therapist and because of repetition-compulsion the patient will repeat the same interpersonal pattern: "in every analytic treatment, the patient develops, without any activity on the part of the analyst, an intense affective relation to him ... It must not be assumed that analysis produces the transference ... , it only unmasks it." (Freud, 1926, p.75). Seminal in questioning the view of transference as purely a repetition and arguing that aspects of the analyst or their behaviour can shape the emerging transference was Bibring-Lehner (1936). At this time Rioch (1943) too argued that "Freud gives the impression that under the stress of the repetition-compulsion the patient is bound to repeat the identical pattern, regardless of the other person. I believe that the personality of the analyst tends to determine the character of the transference illusions... " (p.148). Certainly the research presented here suggests that the theoretical orientation of the therapist and their ensuing technique in the consulting room shapes explicit and implicit transference references as well as other aspects of the patient-therapist relationship, including patients' negative comments about therapy.

The early psychoanalytic literature had debated whether transference was a unique product of pathology and of the analytic encounter or a pervasive aspect of all relationships. Certainly the former views would not be compatible with transference reflecting the existence of a pervasive internal object world mediating and structuring all current relationships and therefore of relevance to cognitive-behaviour therapy. Macalpine (1950) notes a progression from its initial position as pathognomonic of hysteria, to its later finding in other neurotic conditions, to later still it being

found that students in training analyses formed transferences too. Klein in 1952 writes of transference as a universal mechanism, "in some form or other transference operates throughout life and influences all human relationships ....". (p.433). This position implicates it permeating therapies of other theoretical approaches albeit, as noted above, that its elucidation may vary.

This study did find transference references in all therapies. It also found that patient implicit transference references were high and notably so in cognitive-behaviour therapies toward the therapy and therapist. It documented the level of patients' negative comments about the therapy and therapist and how cognitive-behaviour therapists tended not to facilitate the expression and resolution of these comments and in fact were more usually restrictive in their responses. It was therefore argued that cognitive-behaviour therapy would benefit from addressing strains in the therapeutic alliance and that the psychoanalytic concept of transference contributes one framework of understanding to so do. It was also argued that to take this up may increase patient adherence to cognitive and behavioural programmes, decrease premature termination, and improve therapeutic outcome. In addition, it is argued that consideration and exploration of the transferential patient-therapist relationship increases knowledge of the intrapersonal and interpersonal workings of the patient and provides a working platform on which to address and resolve difficulties in both.

This thesis' results showed that although transference references occurred in all therapies they occurred more in the psychodynamic and psychoanalytic psychotherapy groups than in others. Why? Macalpine (1950) explained the intensity of transference in psychoanalysis as due to the reduction in external stimulation such as through lying on the couch, the constancy of the analytic environment stimulating fantasy, interpretations which appeal to infantile issues, and the diminished responsibility of the patient. She goes on to argue that a negative transference is also facilitated as the patient "comes to analysis with the hope of being helped. He thus expects gratification of some kind, but none of his expectations are fulfilled. He gives confidence and gets none in return; he works hard and expects praise in vain. He confesses his sins without absolution given or punishment proffered." (p.527). In addition the results of this study have suggested that psychodynamic and psychoanalytic psychotherapists encourage transference references through what they focus on and by the attention they give it. This is in line with Greenberg, Rice and Elliott (1993) who argue that a primary objective of emotionally focused therapies is to evoke emotional experience in order to increase awareness of emotion and to integrate reason and emotion. Patients are encouraged to focus their attention on their evolving emotional experience, to put this into words and to thereby resolve or come to terms with cognitive-affective problems. Furthermore, argues Strachey (1934), mutative interpretations "must be emotionally 'immediate' " (p.147) and this emotional immediacy "is nearly always to be found in the transference" (p.151).

8.3 Evidence-based practice

Evidence-based practice, though not new, has become increasingly central to healthcare thinking as part of clinical governance initiatives to improve clinical and cost effectiveness. Roth (1999) notes limitations of evidence-based practice including the application of therapeutic techniques in a manner unrepresentative of usual clinical practice and a research population atypical of the client groups of most National Health Service psychological services (cf. Parry and Richardson, 1996).

The NHS Executive review (NHSE, 1996) of strategic policy pertaining to psychological therapies noted "the weaknesses of psychotherapy research in relation to external validity are severe" and that "research evidence suggests that specific treatment approaches (as represented by 'brand name' therapies) are not the major determinants of outcome, compared with other factors..." (p.42). That is, that a significant part of the variability in therapy outcome studies is not explained by differences in the therapies themselves.

The confounding contribution of therapist effects in comparative outcome research has long been of concern (cf. Beutler, Crago and Arizmendi, 1986). Luborsky et al (1986a) for example, in comparing studies of short-term psychodynamic psychotherapy, cognitive-behaviour therapy, supportive psychotherapy, and drug counselling found that claims for between therapy differences were often smaller than variance attributable to therapists. In referring to therapist factors, Roth and Fonagy (1996) argue that although specialist extended clinical training and clinical experience may be of less relevance in first time referral primary care settings, that in work with more disturbed patients they are important. With these patients, such as those with borderline personality disorder, this experience and the associated ability to maintain a therapeutic alliance may be crucial (cf. Crits-Christoph and Mintz, 1991). Apart from the association between therapist experience and premature termination (cf. Slipp and Kressel, 1978; Crits-Christoph, Barnackie, Kurcias, Beck et al., 1991; Sue, McKinney and Allan, 1976), Horvath and Symonds' (1991) meta-analytic study found a 26% difference in outcome across therapies attributable to the quality of therapeutic alliance. Krupnick et al (1996) in the National Institute of Mental Health trial of treatments for depression found that the therapeutic alliance accounted for 21% of the variance in Beck Depression Inventory and Hamilton Rating Scale of Depression scores. They also found that it significantly impacted on remission rates with every increase of one point on the five point alliance scale leading to a thirteen fold increase in the odds of remission. Luborsky, McLellan, Woody, O'Brien and Auerbach (1985) too found therapeutic alliance correlated with outcome and that a good therapeutic alliance facilitated adherence to the intended treatment programme. By implication, with more disturbed patients, if not with all, there is a need to work with interpersonal aspects of the patient-therapist relationship which may impede the delivery of techniques.

The therapeutic alliance, nurtured within a transference informed framework, has long been seen as a cornerstone of psychodynamic psychotherapy (cf. Greenson, 1965) with some analysts valuing the mutative power of the patient-therapist relationship as much as that of the interpretation (cf. Greenberg, 1996; Stern et al, 1998; Wolf, 1988). Gaston (1990) has suggested that it may be the most robust predictor of outcome and found alliance ratings substantially contributed to outcome in brief psychodynamic psychotherapy. It has more recently received greater attention in cognitive-behaviour therapies (e.g. Rush, 1985; Safran, 1998, Safran and Segal, 1996) with Luborsky et al. (1985) finding alliance ratings positively correlated with outcome in cognitive therapy and Cross, Sheehan and Khan (1982) to changes in self-perception and behaviour in behaviour therapy. Gaston, Marmar, Gallagher and Thompson (1991) found that the strongest associations between alliance and outcome were in behaviour and cognitive therapy, rather than in psychodynamic psychotherapy. They also found substantial increases in outcome variation accounted for by alliance scores in late sessions over those in early sessions of these therapies. Their finding compliments those about transference references and negative patient material in this study and supports the argument put forward above that discord in the therapeutic alliance may become a growing problem in the course of therapy, and on its outcome, if the transferential patient-therapist relationship and implicit as well as explicit patient negative material about it are not worked with.

There is evidence (e.g. Henry et al, 1993) that rigid adherence to therapy protocol can lead to a decrement in outcome. Roth (1999) suggests this is because such adherence can be to the neglect of the therapeutic alliance and writes "the alliance requires a capacity to create an environment in which technique can be implemented in the context of a trusting and collaborative framework. Because the alliance is capable of shifting from session to session, and from moment to moment, skilled therapists need simultaneously to attend to several levels of discourse." (p39). This study has found wide variations across therapies in their addressing of overt and covert aspects of the patient-therapist relationship, including of transference and of negative feelings, and which are pertinent to maintaining an alliance. Interestingly, Castonguay et al (1996) found that in a study of cognitive-behaviour therapy where a focus on intrapersonal links was positively correlated to depressive symptoms post therapy, that this was due to problems in the therapeutic alliance.

The utility of evidence-based practice is currently limited by a significant part of the variability in many therapy outcome studies being explainable not by differences in the therapies themselves but by therapist effects. One of the more important therapist effects, in particular in work with disturbed patients, is that of experience. There is converging evidence that one artifact of therapist experience can be skillful monitoring of the patient-therapist relationship at an implicit as well as

explicit level thereby maintaining a therapeutic alliance which minimises attrition and maximises therapeutic outcome.

8.4 Some Comments on Methodology

All psychoanalytic schools, and in particular the Kleinian (cf. Joseph, 1971), pay careful attention to the state of mind which the patient induces in the therapist. As discussed in Chapter Two, psychoanalysts use their own finely tuned introspections to vicariously introspect their analysands' psyches. This technique, the underpinning rationale of which is the psychoanalytic concepts of projection and projective identification, is in effect therapists' monitoring the effect on them of the subtle and not so subtle nuances of patients' interpersonal enactment of their intrapersonal, internal object relational, world in their relationship with the therapist. Truly psychoanalytic data is therefore subjective as well as objective in its derivation. The Transference Coding System applied as it is from outside the consulting room cannot directly access the subjective dataset and therefore loses some of the full richness of the transferential relationship. This is a limitation of other rating instruments too and the Transference Coding System has advantages over these as a manualised instrument which can go beneath the overt content of both patient and therapist narratives to rate their covert content. It has also demonstrated good inter-rater reliability, as did the Coding System of Therapeutic Focus and the rating of patients' negative comments about therapy/therapist and therapist reponse to them.

Some specific interventions are reliably shown to be more effective in the amelioration of some circumscribed problems e.g exposure in the treatment of phobias. But generally psychotherapy comparative outcome literature has not shown one type of psychotherapy to be consistently more effective than others (Wampold, Mondin, Moody, Stich, Benson and Ahn, 1997). Indeed, as noted above, other factors, such as therapist characteristics, the therapeutic alliance and client characteristics have been shown to make a significant contribution to outcome across schools. Researchers such as Goldfried and Padawer (1982) have argued that to clarify the paradox of divergent schools of theory showing equivalence of outcome, research is needed on therapists' general strategies of intervention. The work reported here has undertaken such research analysing the focus of therapist interventions and therapist response to patients' negative material about the therapy and therapist.

Roth (1999) in discussing evidence-based practice notes that much psychotherapy research is of limited generalisability because it applies therapeutic techniques in a manner unrepresentative of usual clinical practice and with a research population atypical of the clinical population of most

NHS psychological services. The validity of psychotherapy research may also be flawed by the use of therapists who are insufficiently trained and with limited expertise in the therapy they are administering. This may be particularly problematic in comparative research including psychodynamic psychotherapies which require lengthy training and which research suggests do not, unlike with cognitive-behaviour interventions, tend to achieve good outcome with a limited training. This study researched National Health Service patients in therapy with National Health Service therapists, experienced, trained and qualified to a high standard in the therapy model they were delivering. Such research of psychological therapy delivered in the field has been highlighted as a priority in the current National Health Service Research and Development Strategy (1999). The study also researched what therapists actually did rather than what they said they did. Strupp (1983) in an article entitled *Are Psychoanalytic Psychotherapists Beginning to Practice Cognitive Behaviour Therapy or Is Behaviour Therapy Turning Psychoanalytic?* noted a difference between what therapists did in the consulting room and what they would be expected to do given their theoretical background. This study too has noted some such differences. The one area in which the study's findings may be of limited generalisability is that of its clinical population. The patients researched suffered with the anxiety, depression and relationship problems that typify the caseload of most psychology and psychotherapy services. However, further research could also usefully explore the treatment of people with more severe psychological problems such as borderline personality disorder. In so doing it could also compare the new cognitive-behaviour therapies evolved to work with such disorders e.g. cognitive-analytic and dialectical behaviour therapies with the psychodynamic therapies researched in the current study.

Sample sizes for analyses of the interaction of type of therapy and early and late sessions of therapy were limited. Some trends were shown, for example in late sessions over early of cognitive-behaviour therapies a reduction in explicit references to conflict and increase in implicit references to the therapist and conflict. But few of the trends were significant and further research could usefully re-examine these comparisons with a larger sample size. Further research could also, as noted above in discussion of therapist linking of references, helpfully analyse therapist linking of implicit references to transference components. The large number of statistical tests undertaken leaves the possibility of a small number reaching significance by chance. There was no evidence supporting this theoretical possibility impacting on the research findings. Stringent significance levels were set to test hypotheses ($p<0.01$), obtained significance levels were typically well in excess of this, and significant results tended to show a trend across percentage, mean and rate data and across the two therapy groupings as well as the six therapy groups In addition the findings in the main study tended to replicate those found in the pilot study.

On many comparisons the conversational therapy group was significantly different from the other psychodynamic psychotherapy groups and not significantly different from the cognitive-behaviour therapy groups. This replicated the findings of the pilot study which were explained as probably arising from the treatment focus of conversational therapy. It was noted it shared with psychodynamic psychotherapy the belief that patients enacted, within the patient-therapist relationship, their problems which were then relieved through exploration, insight and re-adjustment of the relationship. But unlike psychodynamic psychotherapy, it focused more fully on current life and made frequent references to current significant others.

8.5 Concluding Comments

For more than a century a belief in the concept of transference and its centrality to the mutative process has been a unifying force amongst a diversity of psychodynamic therapies. Esman (1990) notes that:

> None of Freud's epochal discoveries - the power of the dynamic unconscious; the meaningfulness of the dream; the universality of intrapsychic conflict; the critical role of repression; the phenomena of infantile sexuality - has proved to be more heuristically productive or more clinically valuable than his demonstration that humans regularly and inevitably repeat with the analyst and with other important figures in their current lives patterns of relationship, of fantasy, and of conflict with the crucial figures in their childhood - primarily their parents (p.1).

However, whilst a unifying force, transference itself has evolved a diversity of conceptualisations over the last century and many continue to co-exist. Freud for example referred to transference both as the whole of the affective, cognitive and behavioural relationship between patient and therapist and also in a narrower sense as just pathological manifestations derived from patients' unresolved conflicts. Others have debated whether transference is a manifestation of the therapeutic relationship alone or the manifestation of a pervasive internal structure formed within significant early relationships; a template which mediates our experience of our external and internal world. Further debate, over whether transference is rational or irrational is most probably an unhelpful dichotomy (indeed as Macalpine (1950) noted it was psychoanalysis which argued that rational behaviour can be traced back to irrational roots) as is whether transference is experienced as an "intrusive foreign body" (A.Freud, 1947) or as gratifying (Alexander and French, 1946). And the relative values of intellectual insight versus affective re-experiencing aired in the early 1920s continues to a lesser or greater degree in psychoanalysis for example between

Kernberg and Kohut and outside of it between cognitive-behaviour, cognitive analytic and dialectical behaviour therapies.

Despite the diversity of conceptualisations of transference that have existed, this study's conceptual analysis of transference definitions found a shared common ground of understanding as to its nature. I have argued that transference is a universal psychical phenomenon derived from an internal world mediating and structuring ones sense of self and the external world and that it is therefore a part, not just of psychodynamic therapies, but of all therapies and all human relationships. In this I am on strong ground shared with allies better than I. For example, Bird (1972) states "transference is a universal mental function which may well be the basis of all human relationships" and that it assumes the "characteristics of a major ego function". (p.267); Klein (1952) writes that "in some form or other transference operates throughout life and influences all human relationships ....". (p.433). British Kleinian, Independent and Neo-Freudian schools share the view that patients enact their internal object relations interpersonally in the transferential patient-therapist relationship (cf. Joseph, 1975, Stewart, 1990 and Sandler and Sandler, 1984, respectively) and that the "central plank in any therapeutic endeavour is a rigorous and detailed exploration of the transference/ countertransference interaction." (p.244).

As discussed above, support was forthcoming within this study for the view that patient references to transference components are not unique to psychodynamic psychotherapies but occur in cognitive-behaviour therapies too. However, the frequency of these references was lower in cognitive-behaviour therapies and it is suggested that the structure and process of psychodynamic psychotherapies, in particular therapist behaviour, encourages, as it is designed to, the expression and elucidation of transference. Certainly psychodynamic psychotherapists made more links between transference references and explored transferential and non-transferential aspects of the patient-therapist relationship more. By contrast patients' explicit references to current thoughts or feelings about the therapist or therapy were little addressed by cognitive-behaviour therapists. It was therefore of note that in these groups implicit references to the therapist were much higher than their respective explicit references, that there were also high levels of negative feelings, and that late sessions saw a rise in implicit references to both. Ferenczi's (1909) statement comes to mind that "the critics who look on these transferences as dangerous should condemn the non-analytic modes of treatment more severely than the psycho-analytic method, since the former really intensify the transferences, while the latter strives to uncover and to resolve them as soon as possible" (p.57). So too does Freud's (1923) statement that such material unrecognised and unaddressed forms a significant obstruction to the work of therapy, but when recognised and addressed "the most powerful therapeutic instrument..." (Freud, 1923, p.247).

Analysis of the patient-therapist relationship is, and should be, central to psychodynamic psychotherapies. But such analysis, both from a transferential and non-transferential perspective, may also be beneficially embraced by cognitive-behaviour therapies. Some now are, to a degree, (for example, cognitive-analytic therapy and dialectical behavioural therapy), and in particular in its negative aspects, so as to maintain the therapeutic alliance and repair ruptures to it, thereby potentially improving outcome (cf. Padesky, 2000). This study found a high level of focus on interpersonal factors by therapists in cognitive-behaviour therapies as well as in psychodynamic therapies. Though Kerr et al (1992) found that whereas such interpersonal focus positively correlated with outcome in psychodynamic psychotherapy in cognitive-behaviour therapy it did not. Messer writing in 1986 noted that:

> behaviour therapy, having regained the mind it lost, has become far friendlier than it once was to the cognitive concepts of psychoanalysis. This flirtation is not mere conditioned eyelash batting but penetrates even to the heart of the flirted-with object, namely, unconscious processes. (p.1261).

Cognitive-behaviour therapies, though some may not recognise it and others may be too bashful to admit it, are now attracted to concepts of psychoanalysis which can further, and helpfully, inform their focus on interpersonal factors and the unconscious intrapersonal factors underlying them. Transference is such a concept and its consideration may provide further understanding of patient pathology and a framework within which to more fully make use of the therapeutic potential inherent in the patient-therapist relationship and its exploration.

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APPENDIX I

Application for Ethical Approval

THIS FORM SHOULD BE COMPLETED IN TYPESCRIPT AND RETURNED TO THE SECRETARY, INSTITUTE OF PSYCHIATRY

INSTITUTE OF PSYCHIATRY
BETHLEM & MAUDSLEY HOSPITAL

REF NO. _____

APPLICATION TO THE ETHICAL COMMITTEE FOR APPROVAL OF A RESEARCH PROJECT

Please read the Notes for Guidance before completing this form

Section 1 Details of Applicant

Applicant DR. M. POWER Status SENIOR LECTURER Signature _____

Address for Correspondence MRC SOCIAL AND COMMUNITY PSYCHIATRY UNIT,

INSTITUTE OF PSYCHIATRY, DE CRESPIGNY PARK, DENMARK HILL, LONDON SE5 8AF

Sponsor N/A Status _____ Signature _____

Investigator MR K BEACH Status PROBATIONER CLINICAL PSYCHOLOGIST Signature _____

DATE OF APPLICATION _____

Section 2 Title of Project

TRANSFERENCE: an empirical investigation of its occurrence and therapist response across a range of psychological therapies.

Section 3 Purpose of Project

(This section should state, **as far as possible in lay language**, the hypothesis to be addressed and the clinical relevance of the study)

1. To investigate whether or not transference occurs in behavioural, cognitive and psychodynamic therapies.

2. To investigate therapist response to transference in behavioural, cognitive and psychodynamic therapies.

Section 4 Conduct of Project

(a) Location MRC Social and Community Psychiatry Unit

(b) Nature of subjects existing tapes of therapy sessions Number 100

(c) Expected duration of project 5 years

(d) Proposed frequency and duration of procedures:

i) for research subjects N/A - only using existing tapes

ii) for controls N/A

(e) Proposed payment (if any) to subjects N/A

(f) Funding (if any) sought for project

Please state i) source N/A

ii) amount _____

iii) to whom payable (please complete whichever is applicable):

_____ (as a personal emolument)

_____ (Institute/Hospital funds)

(g) Will data relating to subjects/controls resulting from the Research be stored on computer? Yes If so, the requirements of the Data Protection Act must be complied with.

(h) Is it proposed to use staff members of the Institute or the Joint Hospital as subjects in this study? No

Does the researcher foresee any interference with their duties? No

(j) Description of design, methodology and techniques

Using transcripts of audio tapes from psychological therapy sessions.
Content analysis of these transcripts, focusing on dyadic interaction sequences.
Descriptive and correlational statistical analysis.

Section 5 Ethical Considerations

(please provide a brief account **in lay language** of any ethic considerations raised by this project)

Subjects have understood that they were being tape-recorded.
Are using tapes which subjects have previously agreed can be used for research purposes.
Are following the original guidelines for their use.

Section 6 Safety and other Controls

(a) Have you obtained a certificate from the Administration of Radioactive Substances Act Committee (ARSAC)? **YES/PENDING/NOT APPLICABLE**
(please attach a copy where applicable, to your application)

(b) Has the project been registered with the Radiation Protection Officer? **YES/PENDING/NOT APPLICABLE**

(c) Have you obtained a certificate from the Committee on the Safety of Medicines? **YES/PENDING/NOT APPLICABLE**
(Please attach a copy, where applicable, to your application)

(d) Have you obtained indemnity from the sponsoring industrial or drug company? **YES/PENDING/NOT APPLICABLE**
(please attach a copy, where applicable, to your application

(e) Please state that you will observe the Code of Practice on the Use of Audio-Visual Materials **YES/PENDING/NOT APPLICABLE**

Section 7 Consents

(a) Please state how you propose to obtain informed consent, how such consent will be recorded, and why you consider the proposed method to be appropriate to this particular project. If you are using a written consent form, please supply a copy.

(b) Please indicate that you have taken account of paragraph 13 in the Notes for Guidance.

Consent was obtained by the original researcher, who made the recordings. If any offer is made to provide new tape recordings, the attached consent form will be used.

UNIVERSITY OF LONDON
BRITISH POSTGRADUATE MEDICAL FEDERATION

THE BETHLEM ROYAL HOSPITAL
AND
THE MAUDSLEY HOSPITAL

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APPENDIX II

Ethical Approval

ETHICAL COMMITTEE

Bethlem Royal and the Maudsley Hospital
and the Institute of Psychiatry

23 May 1991

Dr M Power
MRC Social and Community Psychiatry Unit
Department of Psychiatry

Dear Dr Power

TRANSFERENCE: AN EMPIRICAL INVESTIGATION OF ITS OCCURRENCE AND THERAPIST RESPONSE ACROSS A RANGE OF PSYCHOLOGICAL THERAPIES (40/91)

Thank you for your letter of 23 March in which you deal with the concerns that the Ethical Committee had expressed about this project. The project was approved by the Committee at its meeting on 17 May 1991 on the understanding that you will observe the Code of Practice for the use of audio visual materials wherever the Code appears to be relevant.

Yours sincerely

A Ingle
Secretary

APPENDIX III

Definitions of Transference for Conceptual Analysis I

1) Freud (1895) "...the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. This is frequent, and indeed in some analyses a regular, occurrence. Transference on to the physician takes place through a false connection."

2) Freud (1900) "...an unconscious idea is as such quite incapable of entering the preconscious and ...it can only exercise any effect there by establishing a connection with an idea which already belongs to the preconscious, by transferring its intensity on to it and by getting itself covered by it. Here we have the fact of transference... ."

3) Freud (1900) "...earliest experiences of childhood were not obtainable any longer as such but were replaced in analysis by transference and dreams."

4) Freud (1905) "New editions or facsimiles of the impulses and phantasies which are aroused during the progress of the analysis; but they have this peculiarity, which is characteristic of their species, that they replace some earlier person by the person of the physician. To put it another away: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for their substitution. These then - to keep to the same metaphor - are merely new impressions or reprints. Others are more ingeniously constructed; their content has been subject to a moderating influence...by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that. These, then, will no longer be new impressions, but revised editions."

5) Freud (1912) "In every analytic treatment there arises, without the physician's agency, an intense emotional relationship between the patient and the analyst which is not accounted for by the actual situation. It can be of a positive or negative character and can vary between the extreme of a passionate, completely sensual love and the unbridled expression of an embittered defiance and hatred. This transference - to give it its shortened name - soon replaces in the patient's mind the desire to be cured."

6) Freud (1912a) "It must be understood that each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life. ....This produces what might be described as a stereotype plate (or several such), which is constantly repeated - constantly reprinted afresh - in the course of the person's life. ..... Thus it is a perfectly normal and intelligible thing that the libidinal cathexis of someone who is partly unsatisfied, a cathexis which is held ready in anticipation, should be directed as well to the figure of the doctor ... the cathexis will introduce the doctor into one of the psychical "series" which the patient has already formed."

7) Freud (1914c) "The patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action, he repeats it,

without of course, knowing that he is repeating it. For instance, the patient does not say that he remembers that he used to be defiant and critical toward his parents' authority, instead he behaves in that way to the doctor."

8) Freud (1914g) "What interests us most of all is naturally the relation of this compulsion to repeat to the transference and to the resistance. We soon perceive that transference itself is only a piece of repetition, and that the repetition is a transference of the forgotten past not only on to the doctor but also on to all other aspects of the current situation. We must be prepared to find therefore, that the patient yields to the compulsion to repeat, which now replaces the compulsion to remember, not only in his personal attitude to his doctor, but also in every other relationship which may occur in his life at the time."

9) Freud (1917) "We mean a transference of feelings on to the person of the doctor ... we suspect ... that the whole readiness for these feelings is derived from elsewhere, that they were already prepared in the patient, and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor."

10) Freud (1920g) "These reproductions which emerge with such unwished for exactitude, always have as their subject some portion of infantile sexual life, of the Oedipus Complex, that is and its derivatives and they are invariably acted out in the sphere of the transference and of the patient's relation to the physician."

11) Freud (1920g) "The patient cannot remember the whole of what is repressed in him ... is obliged to repeat the repressed material as a contemporary experience instead of, as the physician would prefer to see, remembering it as something belonging to the past."

12) Freud (1926) "The patient is repeating in the form of falling in love with the analyst mental experiences which he has already been through once before; he has transferred on to the analyst mental attitudes that were lying ready in him and were intimately connected with his neurosis. He is also repeating before our eyes his old defensive action; he would like best to repeat in his relation to the analyst all the history of that forgotten period of his life. So what he is showing us is the kernel of his intimate life history; he is reproducing it tangibly; as though it were actually happening, instead of remembering it."

13) Freud (1933) " ... forgotten and repressed experiences of childhood are reproduced during the work of analysis in dreams and reactions, particularly in those occurring in the transference, although their revival runs counter to the interest of the pleasure principle, and we have explained this by supposing that in these cases a compulsion to repeat is overcoming even the pleasure principle."

14) Freud, A. (1936) "By transference we mean all those impulses experienced by the patient in his relation with the analyst which are not newly created by the objective analytic situation but have their source in early - indeed the very earliest object relations and are now merely revived under the influence of the repetition compulsion."

15) Fenichel (1946) "The repetition of previously acquired attitudes toward the analyst ... the patient obviously misconstrues the real situation and loves or hates the analyst for something, which in the judgement of the analyst, is nonexistent ... in the transference the patient misunderstands the present in terms of the past; then instead of remembering the past, he strives, without recognising the nature of his action, to relive the past and to live it more satisfactorily than he did in childhood. He 'transfers' past attitudes to the present."

16) Silverberg (1948) "... an attempt to learn, by a series of rehearsals how not to be helpless or powerless in a situation which originally found us so. ... Every transference indicates a need to exert complete control over external circumstances."

17) Chance (1952) "... the patient's tendency to respond to the therapist with feelings, attitudes and behaviour which are stereotypes or clichés of his childhood experiences in relationship with the parental figure which had been more important in his development."

18) Waelder (1956) "... an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and fantasies of his childhood."

19) Rawn (1958) "... an unconscious polarised emotional set representing a repetition in the present of past emotional states."

20) Greenson (1965) "Experiencing feelings, drives, attitudes, fantasies and drives toward persons in the present which are inappropriate to that person and a repetition, a displacement of reactions originating in regard to significant persons of early childhood. I emphasise that for a reaction to be considered transference it must have two characteristics: it must be a repetition of the past and it must be inappropriate to the present."

21) Rosenfeld (1965) "... every aspect of the patient's involvement with the therapist is seen as a repetition of past relationships."

22) Crisp (1966) "Behaviouristically, 'transference' attitudes may be said to be inappropriate and indiscriminate social responses that have generalised from earlier firmly established (fixed) responses."

23) Greenson (1967) "It is inappropriateness, in terms of intensity, ambivalence, capriciousness, or tenacity which signals that the transference is at work."

24) Mueller (1968) "... attribute motives and feelings to their therapists and react to these attributions on the basis of their expectations derived from previous conflicted interpersonal relationships."

25) Sandler, Dare and Holder (1970) "... the term 'transference' is used by different psychoanalysts in some or all of the following senses:

i) to describe the treatment alliance
ii) to denote the emergence of infantile feelings and attitudes in a new form, directed towards the person of the analyst, essentially as described by Freud.
iii) to include 'transferences of defence' and 'externalisations'.
iv) to encompass all 'inappropriate' thoughts, attitudes, fantasies and emotions which are revivals of the past and which the patient may display (whether he is conscious of them or not) in relation to the analyst. This would include such things as the patient's initial 'irrational' anxieties about coming to treatment, particular attitudes towards people which form part of his personality structure and which also show themselves toward the analyst."

26) Truax (1971) "... the similarity of feelings toward the therapist to those occurring in childhood toward the parent; in this sense, the feelings of the patient, can be thought of as being 'transferred' from the basic family model relationship to the relationship with the therapist."

27) Rhoads and Feather (1972) "... the transfer to the therapist of attitudes appropriate to other persons past or present in the patient's life, and inappropriate to the therapist."

28) Lower, Escoll, Little and Ottenberg (1973) "... a revival of attitudes and feelings originally belonging to relationships with figures in the patient's early life and expressed toward current objects, in particular the analyst."

29) Luborsky, Graff, Pulver and Curtis (1973) "... the revival in a current object relationship, especially to the analyst, of thought, feeling, and behaviour derived from the repressed fantasies originating in significant conflictual childhood relationships. Such a definition allows distinction between past and present (genetics), character and fantasy (structural), infantile and mature aims (dynamic), conscious and unconscious, (topographic), repressed and derivated (economic), appropriate and inappropriate (adaptive)."

30) Sandler, Dare and Holder (1973) "a specific illusion which develops in regard to the other person, one which, unbeknown to the subject, represents, in some of it's features, a repetition of a relationship towards an important figure in the past."

31) Blanck and Blanck (1974) "Transference refers to those feelings and attitudes that belong to past objects and that are displaced and projected onto the therapist, mistaking the past for present."

32) American Psychiatric Association (1975) "Transference is the unconscious assignment to others of feelings and attitudes that originally were associated with important figures in one's early life. The transference pattern follows the pattern of it's prototype."

33) Langs (1976) "... totality of all intrapsychic components of the patient's fantasies about and reactions to the analyst."

34) Sandler (1976) "Transference need not be restricted to the illusory appreciation of another person...., but can be taken to include the unconscious (and often subtle) attempts to manipulate or provoke situations with others, which are a concealed repetition of earlier experiences and relationships."

35) Graff and Luborsky (1977) "... the degree to which the patient is dealing with material that is overtly or covertly related to the analyst. This material would be a manifestation of or displacement from an early important object relation. The previous object, however, does not have to be mentioned; it may be inferred by the rater because of the presence of distortion, strong affect, inappropriateness etc.."

36) Segal (1981) "... all aspects of the patient's communications in a session contain an 'element of unconscious phantasy', even if they appear to be concerned with external facts."

37) Grotstein (1981) "transference occurs as a projective identification of aspects of the self (including the displacement of past projective identifications) in the present into or onto the figure of the analyst."

38) Waterhouse and Strupp (1984) "... displacement of wishes, affects, and attitudes experienced toward earlier figures in the patient's past onto contemporary transactions in which the same contingencies do not apply."

39) Erdelyi (1985) "... the tendency of patients, regardless of sex, to develop passionate feelings of love ("positive transference") and hate ("negative transference") toward their therapist."

40) Rycroft (1985) "1. The process by which a patient displaces on to his analyst feelings, ideas, etc., which derive from previous figures in life; by which he relates to his analyst as though he were some former object in his life; by which he projects on to his analyst object representations acquired by earlier introjections, by which he endows the analyst with the significance of another, usually prior object. 2. The state of mind produced by 1. in the patient. 3. loosely, the patient's emotional attitude toward his analyst."

41) Chessick (1986) "Transference is a form of resistance in which patients defend themselves against remembering and discussing their infantile conflicts by reliving them. It also offers us a vital and unique clinical opportunity to observe and experience derivatives of the past directly and thereby to better understand the development of the nuclear childhood conflicts in the patient."

42) Laplanche and Pontalis (1988) "... a process of actualisation of unconscious wishes. Transference uses specific objects and operates in the framework of a specific relationship ... infantile prototypes re-emerge and are experienced with a strong sensation of immediacy."

43) Olsson (1988) "... compulsion to repeat a pattern of behaviour. A concentration of past attitudes and feelings, inappropriate to the present."

44) Curtis (1973) "Transference is the revival in a current object relationship, especially to the analyst, of thought, feeling and behaviour derived from repressed fantasies originating in significant conflictual childhood relationships."

APPENDIX IV

Definitions of Transference for Conceptual Analysis II

1) Baron, C. (1987) "the patient transfers to the analyst feelings and ideas appropriate to significant figures in his childhood and by extension to all feelings experienced by the patient in relation to the therapist".

2) Belki, G. S. (1980) "transferring onto the person of the analyst feelings that were once attached to emotionally significant figures early in life".

3) Bloch, S. (1982) "the transference of infantile and childlike feelings and attitudes to the therapist which were previously directed to key figures in the patient's earlier life".

4) Brown, D. and Pedder, J. (1979) "to experience feelings toward the therapist as if he were a significant figure from the past".

5) Brown, D. and Pedder, J. (1979) "inner representations of figures from the past become superimposed on the image of the therapist, feelings are expressed toward him that belong to the past. The consciously forgotten becomes re-enacted in the present .."

6) Cramer, D. (1992) "transfer to the therapist their feelings about the significant figures in their life, who were typically their parents".

7) Dolto, F. (1974) "In general, the process by which certain unconscious desires attach themselves to certain objects. A transfer involves the repetition of prototype reactions lived through in infancy; as a result the objects of a transfer are endowed with a heightened affective load or coloring; they are valorized. The analyst, like the father, readily serves as an object of transference. In this case, the subject projects his own personality onto the analyst, and sees him as a mirror of himself. This transference is viewed as a necessary step in analysis, the subject being able to recognise in the analyst traits he would not have been able to recognise directly in himself.

8) Freud, S. (1910) "The patient, that is to say, directs towards the physician a degree of affectionate feeling (mingled, often enough, with hostility) which is based on no real relation between them and which - as is shown by every detail of its emergence - can only be traced back to old wishful fantasies of the patient's which have become unconscious. Thus the part of the patient's emotional life which he can no longer recall to memory is re-experienced by him in relation to the physician".

9) Hildebrand, P. (1983) "Emergence of infantile feelings and attitudes in a new form as centrally directed toward the person and the therapist. It is a term which is used to encompass all inappropriate thoughts, attitudes and emotions which are revivals of the past and of past relationships which the patient may show whether or not he is conscious of them in relation to his therapist".

10) Holmes, J. and Lindley, R. (1989) "refers to the way in which the feelings, wishes and actions of the patient in relation to the therapist may be unconsciously influenced, coloured, and distorted by earlier childhood experiences, especially those with parents".

11) Klein, M. (1952) "here I a concerned with the manifestations of transference in psycho-analysis. It is characteristic of psycho-analytic procedure that, as it begins to open up roads into the patient's unconscious, his past (in its conscious and unconscious aspects) is gradually being revived. Thereby his urge to transfer his early experiences, object relations and emotions is reinforced and they come to focus on the psycho-analyst; this implies that the patient deals with the conflicts and anxieties which have been reactivated by making use of the same mechanisms and defences in earlier situations".

12) Lagache, D. (1953) "a repetition in present-day life, and particularly in relationship to the analyst, of unconscious emotional attitudes developed during childhood within the family group and especially toward the parent".

13) Lomas, P. (1981) "inappropriate expectations derived from past experience".

14) Menninger, K. A. and Holzman, P. S. (1973) "the unrealistic roles or identities unconsciously ascribed to an analyst by a patient in the regression of psychoanalytic treatment and the patient's reactions to these representations usually derived from earlier experiences".

15) Rosen, B. (1986) "Those aspects of the therapeutic relationship which reflect and impinge upon the patient's (often) unexpressed fantasies, conflicts and expectations".

16) Sainsbury, M. J. (1974) "consists of the projection of feelings, thoughts and wishes on to the analyst who comes to represent to the patient someone from his (the patient's) past. It is believed that such feelings, thoughts and wishes transferred to the therapist were present in the patient's infantile and childhood relationships with his parents".

17) Weiner, J. (1976) "which consists of positive or negative feelings and attitudes originally held toward other people in their life and now transferred without justification in reality to the person of the therapist".

18) Wolf, E. (1988) "an experience that involves intense feelings about the therapist, and these feelings must be related to the feelings associated with some traumatic events involving significant persons of the patient's early life".

19) Wolf, E. (1988) "transferences are the fears, defences and the distortions imposed by early traumatic threats to the self that manifest in relations with others in later life when they are no longer appropriate".

20) Wolff, H. (1983) "that process by which the patient is experiencing feelings, thoughts and phantasies in relation to the therapist which, instead of being based on present day reality, are at least in part based on feelings and thoughts the patient has previously experienced in relation to significant people in his past and which are displaced or transferred on to the therapist".

21) Wolff, H., Bateman A. and Sturgeon, D. (1991) "the process by which the patient transfers on to his analyst past experiences and strong feelings e.g. of dependency, love, sexual attraction, jealousy, frustration or hatred which he used to experience in relation to significant persons such as his mother, father or siblings earlier in life".

APPENDIX V

Transference Coding System: Guidelines on Rating

General Guidelines

The following guidelines were produced from the pilot rating phase:

Each statement is rated separately i.e. without reference to the previous statement or previous statements. The transference *process* is **not** being rated and raters should not look further back or forward in the transcription for additional material. It is, however, permissible to look to the previous statement i.e. from patient to therapist statement or therapist to patient statement to clarify what is being referred to in the statement being rated.

Questions asked by the patient or therapist are rated as if they were statements. So that, "Do you feel that you see me like your father?" is rated the same as "You see me as your father". But "How do you feel" is not a feeling though it may imply one.

Short statements such as "Yes" or "That's right" are unlikely to be ratable, unless a clear endorsement of a previous relevant statement.

Implicit references by therapists are rated regardless of whether the therapist appears aware of their presence.

Many factors may suggest the presence of implicit references. The awareness of the rater to possible implicit transference references should be alerted by reference to: other professional carers; teachers, policemen or policewomen, and other authority or parental figures; institutions such as school (learning), hospital (caring); all manner of regular meetings and regular events; talking or sitting; searching for an understanding of things; change, feeling exposed, new things; journeys; strangers, unknown people, people who say little. Possible references to childhood feelings should be alerted by reference to isolation, attachment, abandonment, envy, falling, falling apart etc.. Because of the nature of the inferential processes involved implicit ratings are likely to be less reliable than explicit ratings.

Guidelines on Rating Specific Codes

1. Reference to therapist/therapy - does not include "in our meeting" or "last week" but should include such statements attached to a feeling/though/behaviour/attitude, implicitly or explicitly. Homework is a part of therapy.

2. References to past significant others - brothers, sisters, grandparents (unless primary caretakers), husband/wife. Family are past significant others not caretakers.

3. References to caretakers - parents or other figures if the patient was brought up by them, i.e. they were primary caretakers.

4/5/6. References to feelings etc. - present feelings etc. refer to those which are current or of the last few weeks. Childhood feelings refer to those before the age of eleven, or that can almost certainly be assumed to be so. Past feelings are between the age of 11 and the present.

They include feelings that may only possibly belong to childhood. A general comment as to how people feel, either by the therapist or patient, may possibly be rated as 4i.

7. References to conflict - Intrapersonal: between opposing wishes or needs of self. Interpersonal: between self and other/s. Self criticism in itself is not conflictual if ego-syntonic, that is compatible with self ideals or perception of self. But seeing oneself as "horrible" whilst expressing a wish to be "nice" is. Consciously denying one's needs is conflict. Guilt is conflictual because of having done something which one feels bad about or wishes one had not done. Conflict may be between an implicit and explicit wish.

APPENDIX VI

Example Transcription

HDX/1.0 - C/K
TRANSCRIPT 3/097 PATIENT 2 SESSION 3

T. So, nice to see you again. How have things been in the week.

P. Dreadful

T. Uh huh

P. Hit me like a rock. Next day well I didn't really know what was going on, and I assumed it was something to do with what had happened the day before and I just felt very irritable and tense and very down, um, and that was Thursday, then Friday, I haven't worked since Thursday 'cause I've been on leave and on Friday and the week-end I just don't know what happened I, I cancel, I just couldn't go out at all. I cancelled the two arrangements I'd got for Saturday and Sunday and just didn't see anybody, I just, I don't know, I was you know, in a real pit I've recovered a bit now.

T. Yes. Have you any sense what's going on you know, what particularly in the session that upset you or ?

P. I don't think it was particularly the session, I think it was the fact that now I'm actually trying to do something about it, I can't actually deny it.

T. Mm, right.

P. And the session just took the padding away and the brick wall down and um,

T. Right, so in a sense you have to face the issues. Right. OK.

P. I'm not sorry about it but I suppose it took me a bit by surprise.

T. OK. Right. Perhaps that's something we ought to talk a bit about in today's session you know, is that something you want to talk about. It might be a good idea to sort of you know, like last time we set an agenda about you know what we want to talk about this session, um, normally this at this stage one of few things would probably be enough um or else it would make too long a list then we wouldn't be able to finish what we said in an hours time is that OK. Right. OK, let's make a list of things. By the way as I said last time you know, if you want to take notes during the sessions please. Do you want some paper just in case in want to write anything down. Yeah.

P. Thanks.

T. OK. This is the forms you... for me, thank you. Right. So

P. I got a bit confused about the mastery, the pleasure business was easy to do but the mastery one when I looked

T. Alright. Let's, I think that's something we need to look at any way, you know, sort of the idea of doing homework is so that we have some data to work on. Shall we just put this down on the agenda so the first thing is the feeling dreadful, Thursday to week-end, yeah. Query have to face problems. Being taken away, that's the first thing, the second thing is the um, activity schedule that we need to have a look at. Um, anything else that you thought

P. Well I mean I thought about what you said about tackling these things and the one thing I suppose I really would like to get to grips with, 'cause I, just cause me a lot of heartache is this business of not being able to say to people what I want to say and you know not, not be, not exactly forthright but um, not saying what I want to say and then regretting it afterwards when they've gone.

T. OK. Right. Yep. That's so we've got three things. What I want to put in the list is you know, just to see whether you've got any other thoughts about last session, I want some feedback from you. Yeah. That's probably enough, we've got four things on the agenda. Is there anything that you dying to talk about.

P. No, I think they are mainly the things that I want

T. So OK, just to recap we've got four things here to talk about, one is you're feeling dreadful from Thursday last week, all over the week-end, um, the query 'cause you have to face the problem, the padding has been taken away now so you have to face the problems, the truth, is that the word and the second thing we want to spend some time to talk about the activity schedule particularly the er mastery bit, we want to clarify. The third thing is not able to say to people what you want to say and then regretting it afterwards and the fourth thing is you know, some feedback from you about how you feel about cognitive therapy so far or last session in particular. Yep. Which one shall we start with then?

P. Um, Feedback would be as well 'cause I think feedback will, feedback and the one about feeling dreadful.

T. OK. Why don't we do that. Right. So you came up here on Wednesday and Thursday you were feeling dreadful and you had to cancel your, and it's lasted all through the week-end. Had to cancel your arrangement to go out.

P. Well yeah, I mean Thursday I was working and I just, I mean I felt so wound up it was unbelievable and really irritable and tense and I was driving around thinking I just wanna get this all over and done with and I can't stand any more, I just wanted to burst into tears and so on. I mean by about the afternoon it had worn off a bit. Um, I went out Thursday evening and although that too was a lot of effort. Friday I wasn't working but I was

T. It was your day off.

P. Yeah, I hadn't had any illegal days off and I went, in the morning I did some shopping and in the afternoon I went to visit a friend whose birthday it was but that left me feeling very uneasy and, I dunno, and then I was going out

T. Anything in particular that made you feel uneasy.

P. Well it was the interaction between myself and my friend, 'cause when I, so when I went out Thursday night, I came back thinking why, why did I say that, I shouldn't have said that, what, what do they think of me. Just the the usual sort of things you know, 'cause some, one person I knew there and the other person I didn't know there although they are both nurses.

T. Ok

P. and it just left me thinking I'd left myself wide open and vulnerable and that I shouldn't have said things that I had said. I tried to be constructive and sort of say look I'm quite entitled to

that sort of view and there's nothing wrong with thinking that way and if that's the way I feel about things, then that you know that's alright, but don't think, well I don't know. By the time it came to going out Friday evening, I didn't want to go, I went and I was, was having a sort of knock about at squash with a friend and that was absolutely hopeless, I was just, he said what is the matter with you. He said you're just not with it at all tonight. And in the end, several hours later, we actually got to talking but even then I wasn't able to say what I wanted to say, like you know, I kept thinking of the things when I got home. It's almost as though the panic is so much that it, it masks over what I actually want to say. This sort of a fear. Panic around. And then Saturday morning I bought the paint and I was going to decorate the hall

T. Yes

P. the only, and I did not want to do it, there was no way I wanted anything to do with it but I started it simply because somebody was supposed to come and help me with the high bits, not until Thursday, and

T. That's tomorrow

P. Yeah and then I, and then I just wanted to burst into tears, I was just in a real old state. So much so that I binged all day and made myself feel really ill, did do the decorating, thought well, its not done to my normal sort of standard, it was just done to get it done basically. Cancelled, 'phoned up my friend and lied and said I was ill but I suppose in a way was true because I felt so lousy and I was supposed to be going out for a meal, put him off, 'phoned up my old friend that I was supposed to be playing squash with, put him off for Sunday 'cause I just wanted to be on my own, didn't want anything to do with anybody. Decorated all day and then just wandering around aimlessly in the evenings

T. Uh huh, right

P. and ate and ate on Saturday night. By Sunday I'd got myself a bit more together, then Monday, I was a bit more together and the painting was nearly finished and in fact I'd managed to do all the bits that this person was gonna come and give me a hand with, so I didn't need his help any more and Monday evening I anticipated just having an evening in on my own, just, I sort of got myself sorted by then, I, I, I go through these phases where I knew to be left on my own to do my own thing, for sort of 24, 48 hours, and by Monday evening, afternoon I got myself sort of straight and then decorated, all the pictures were back on the wall, the hall was straight and then a friend 'phoned up out of the blue and asked me to go out for a drink and I said yes, but then after I said yes and I put the 'phone down, I thought well why did I say yes, I didn't really want to go. Anyway I went and we had quite a nice time although I was in a terrible panic in the car about having an accident and getting killed and all these things but I had a reasonable sort of evening.

T. Yes. Right. There's a lot of information there already, you know. Let me just sort of summarise and see whether I got it right. So you came up here to see me on Wednesday, on Thursday you managed to go out and then you afterwards you sort of wonder what do people think of me, you shouldn't have said the things that you said. There were two people there, both nurses, one you knew, one you didn't and then you felt that you left yourself wide open and vulnerable. Even though you had some positive thoughts about you know, I'm entitled to think that way, that's my

P. I tried, I tried to stamp on the negative and think positive about it but I felt as though I had exposed myself totally and that I was was very unsafe.

T. Right. Yes. Uh huh. So you feeling wide open and vulnerable and unsafe, yeah, and you tried to stamp down these negative thoughts by telling yourself you know, entitled to do, you are entitled to think these thoughts sort of point of view if that's how you feel. It didn't seem to help that much. Um, and then prior to that you know on Thursday you were driving around feeling very irritable and tense and said you know, I couldn't stand this any more, I just want to

get this over and done with and that was the thought that came over in your mind. Friday you went out to play squash um not, you weren't with it at all and your friend was saying what's the matter with you. Um, you couldn't say what was the matter, you only, you wanted to um, you know sort of as if the panic, mask what you were going to say. What sort of panic are you talking about at that point.

P. It's just that my mind goes a blank. When I feel, see this was an ex boyfriend and erm, we never sort of did a lot of talking not that that meant anything really and we had sort of a it was something happened, it's better not to say what, on my birthday between him and me and I I suppose I wanted to talk to him about that but I hadn't got the thoughts into my head, it was just this panic that I was, the fear,

T. What sort of

P. Not knowing, could, couldn't get the words into my head 'cause, 'cause of the worry.

T. Can you tell me what the fear was about.

P. What would he say, what would he think.

T. What would you say

P. He would laugh at me.

T. Uh huh. Right. So again it is this idea of like the first day, you know, you are afraid of saying something stupid, that people would laugh at you, you leave yourself vulnerable, people can harm you by picking up on what you said throw it back at you and on Saturday, you know, you started doing some decorating and wanted to, you were feeling so bad that you wanted to burst into tears, you were in a real old state, um, binge all day but you did the decorating in the end, um, not to the usual standard, um, and you rang up your friend and put off going out for a meal, um, also cancelled your arrangement to go out on Sunday. Um, now can you tell me what sort of things go through your mind when you were you know, in a good old state.

P. Just go away and leave me alone. Confusion.

T. Go away and leave me alone. Right.

P. Just felt confused. I don't know what's going on, what I'm feeling.

T. You were feeling confused. Uh huh. What sort of things confused you.

P. Me. You see I don't, I don't, part of me, part of me wanted to sit down and think about what was going on, what I was feeling, what I wasn't feeling, I mean I was feeling hurt in some ways by what had taken place the night before and upset by that. I was also feeling upset because Steve, this married bloke I told you about, I wanted to hear from him and I, I could have 'phoned him but I didn't and he hadn't 'phoned me, not that we'd made any arrangements but um, but I was wondering what he was doing and how he was spending his week-end and all this sort of.

T. Did you wonder why he wasn't ringing you.

P. Um, I don't, well you see he, he sort of said to me look 'phone me any time you want to 'cause he is trying to get things sorted out with his wife at the moment, she left a year ago but they're having, last week they started family therapy. What will be the outcome I really don't know and neither does he but

T. Family therapy, not marital

P. Well marital, well just the two of them, husband and wife, not the girls and so I really feel he is control of his situation and that I am powerless

T. Vulnerable

P. and I just desperately wanted to hear from him and I didn't.

T. Yes. Right.

P. and I just, part of.... if I'd sat down for half an... see if I'd of sat down for half an hour with pencil and paper and though through what I was feeling perhaps hardly any of this would have happened but all I could think of was I've got to get this bloody decorating done, I've got to do it and that sort of pushed everything else aside, sorting out what was going on inside which I suppose I shouldn't have done really but you see half of that, that thought was here in my brain and it didn't actually burst through.

T. Yes, yes, sure, right, yes. So, OK. Right.

P. and there is anger too, a lot of anger.

T. Because you are so powerless, because you know you leave yourself wide open again, that seems to be a theme that's linking these episodes together, for example on um, Thursday, you know, I haven't got details of what you told said to these two people but you were saying that left you wide open you know, vulnerable, and then um,

P. I suppose I feel angry about the state my life's in or the state I'm in I mean I'm just a dead loss. There was right from Thursday there was anger about us, one of things I wrote down.

T. Yes, OK. Right, would look as if you know I pick up a lot as I said, you know, there's a lot of information there, the theme as I sort of floated to you just now was you know this idea of one being laughed at you know, leave yourself vulnerable, saying something silly, stupid that people would pick up again and um, you know, then feeling the idea of powerless and um, you know, um, you are vulnerable again in that sort of situation, it's not something you could do, again you know, much, again on the receiving end as it were. That's seems to be the theme that's linking all these episodes together when you were upset so far from what you told me, does that makes sense to you.

P. Yeah.

T. I'm, just to go with the cognitive model really, now again I haven't got details of the negative thoughts which we need to do when we pick up something you know, later on. What sort of thoughts going through your mind but sounds as if there are some thoughts that seems to go, that's going round your mind and it looks, sounds as if you know, these were the negative automatic thoughts like when you were driving the car, I can't stand any more, I can't stand it any more you know, I would, I want to get it over and done with um, what would people say or think, would they laugh at me, um, the um, you know go away and leave me alone but are these sort of thoughts that frequently occur in your mind, you know, remember reading that little pamphlet about cognitive therapy they talk about the negative thoughts they are automatic, they just come up you know, spontaneously without any trigger um, and it feels true to you you know and that's why that's making you go upset. That explains the mood you people um, so

P. There is this about go away and leave me alone, I mean, that that is when things get really bad that doesn't happen, well happens often, frequent about every fourish weeks I suppose.

T. I couldn't stand any more you know, I want to get this over and done with and these sort of thoughts that come into your find quite frequently. Um, so there seems to be, let's take, so we talk about you know, the theme that's linking it all together seems to be leaving yourself wide

open, saying something stupid, people can harm you, you are in a powerless position, people again can do things to you. What we need, what I sort of suggest that we do now is to pick on one episode really and get some details about you know, what actually happened at that moment. What do you think, what would be a good thing to pick. What about this Thursday, you know, when you had, after you you saw these two nurses, would they

P. I mean I did see Steve last night, he called in on me unexpectedly and the same thing happened then but we will talk about Thursday.

T. What do you prefer

P. I'll talk about Thursday.

T. Talk about Thursday. OK. So you went to see a couple of friends, one is a friend

P. One is a friend and the other one was a friend of hers sort of thing you know

T. Right. So what happened then, they both nurses.

P. Mm, she's a strange, she's a, well I suppose to say she's a friend is a bit of an exaggeration because she doesn't really know a lot about me privately, we know a lot about each other workwise, I don't actually work with her she works at in but um, we think very similarly where where work is concerned and and, for four and a half hours it was nearly all talk about work, which I find dead boring but there were other things, I mean in some ways it's safe to talk about work although they were both very outspoken people and I felt inferior to them.

T. What sort of things you know, they said, make you feel inferior.

P. Um, it was just the way, the way they perceived work and the way work was going and what they were doing at work and um, I don't know, I just felt inferior.

T. Anything in particular that strike you as if you, you know, that made you feel as if you were inferior to them

P. They seemed a lot more confident and a lot more knowledgeable

T. OK. Yep. So what did you talk about then.

P. Um, well the new approach to work, working systems, job hunting, differences in jobs, what jobs we were involved in and, and me and how I felt about my job and what I did in my job. And I just felt as though they were thinking I was stupid and when we were talking about interviews and things I um, one of them, had had cancer of the breast or something, and she said I couldn't go to a job interview because um, that would be held against me. And I said oh I don't know I said I had anorexia and after I said it I felt, Christ what have I done. I said and I still managed to get a job. And that left me feeling totally raw, so I, I, I wont, I don't feel I say things that are really appropriate to the situation, I almost felt as though I was being left out and that somehow I'd got to get myself back into the arena

T. Because you said you were anorexic

P. Not because I said that but just in general the fact that, I mean there was somebody else was said she said about her ex husband and I made some inane comment about my ex husband and after, after I thought about it, 'cause I did go home and think about all this, it was that I felt I was being left out, I was the odd one out and somehow I had to draw their attention to me and make them realise that I was no more the odd one out than they were, I was, on their level. Um, and that I wasn't odd. But the bit about telling them I was anorexia I mean my friend actually knew although I think I remember telling her but I um, I don't know, I suddenly thought crumbs, you know, then that made me guilty and it made me feel guilty and it made feel

as if they were watching what I was eating and then there was this big for me this big show of I'm fine now I'm alright, there's nothing wrong with me.

T. You had a meal together did you ? Yes.

P. and it's almost as though I had to eat too much, I ate more than I anticipated just to prove a point that I was alright.

T. Yes. OK. Right. So again summarising what you told me, you know, these two people, one is a friend or acquaintance, you know, of work, she doesn't know a lot about you but she does know that you had anorexia in the past. The other is a friend of hers, you you were both, you were all talking about work um, you feel a bit, felt a bit inferior because you know they were both very outspoken um, they seemed to know what they were doing and a lot more knowledgeable and confident compared to yourself. Um, then you know, you talk about a new system at work, talk about the differences in jobs and um how you felt about your jobs and what you did sort of thing, you know, again the conversation sort of centered round work. Um, then you had this feeling that you felt they were thinking that you were stupid because you weren't somehow at their level. And one of you, two people said she had breast cancer and she couldn't go for another job and you said, well I don't know I had anorexia, got my job and then after you said that you felt as if you know, you you were being exposed and again being very vulnerable um, people again were judging you and you had... they were watching, you felt as if they were watching what you ate and you had to eat more than you intended to prove that you were fine now. Right. And er, so right. Then you went home and you were feeling quite upset about the episode. Just cast your mind back when you were feeling upset, what were you doing, you were start from when you were at home on your own.

P. What when I got home.

T. Yeah, about how you felt upset, how you felt you know.

P. I just wanted to run away. I, I just, it was late and I had a, had a drink as always to get me to sleep but I didn't go to sleep I just lay there thinking

T. Yes

P. and and just all these thoughts about how I'd shown myself up and

T. What was going through your mind, tell me the details of your thoughts, just cast your mind back as if you were seeing a movie being played, you know

P. Why did I say that, what do they think of me, regret for having said .. somethings .. talking of being inferior

T. I'm inferior, why

P. Will they will Linda ever contact me again, what did she think, what did I .. I felt as though the other girl, the person I didn't know was just looking down her nose at me.

T. Right. So that's a lot of these negative thoughts about the whole thing wasn't it. What did I say, why did I say that, what do they think of me, regret for having said certain things, you know, I'm inferior to them and would they ever contact me again, what do they think you know, they are, looking down at me. These negative thoughts were going through your mind when you were at home, round and round at that point, is that a fair description of that state. What were you, what were your emotions like at that point.

P. I felt very sad, I just wanted to cry.

T. Yes, right. What else. How sad were you when you were you know, from zero to a hundred if I want a rating.

P. 60

T. 60. How much did you believe in what these thoughts in your mind, you know, what do they think of me, I'm inferior to them. Would they ever contact me again, they looking down at me, how much did you believe in that.

P. Quite a lot really I mean I did try and stamp on it

T. How much, how much did you

P. I suppose about only 20% stamping on it the rest was

T. So about 80% that you believed in it. Uh huh. OK. So you know that explain didn't it, why if I had these beliefs you know, if I somehow there's this feeling going through my mind you know, I feel as if I'm exposed, I feel as if you know I'm vulnerable and people would hurt me if I tell them too much about myself, if I reveal my true self, you know, I'm at their mercy. Um, then if I believe that you know, you, I'm inferior to them, if I regret saying certain things that would leave me vulnerable, if I had 80% belief in it then I would certainly feel sad myself. It's just you know, illustrates what the model, the idea of you know how thinking effects how you feel and you believe in it you know of course you know that would lead to that emotional state. I think what you've done though is good, you tried to stamp it out. At this point I think, you know, what we need to do is to collect more information really um, you tried to stamp on it by saying I'm entitled um, to my point of view I believe in it. How much did you believe in that.

P. Not very much really, about 5% I suppose, I tried to do it though

T. You believed in it 5%, right, yes, so having said that you know, to yourself then how much, what were you, how much were you still sad. A rating, a percentage.

P. 60% I thought this always happens

T. About 60%, uh huh, right, it's sort of your past experience. OK.

P. It's just so so difficult to believe that things come really different and that people, will all like me for being me, or will I all, be attractive to other people or want to know me.

T. Is there any evidence against um, the idea that people didn't want to know you.

P. Well yeah, I mean it has happened a lot in the past.

T. Right. Who was these people.

P. Anybody I can think of really

T. Everybody you can think of, OK. Right. So everyone you met in the past didn't like you.

P. Well I don't suppose that's true but I mean that's what it felt like. I mean they like me for a little bit, they like me 'till they found out what I was like and then

T. they just dumped you. Right. It felt like this. OK. Anybody else in your life that you could think of who wasn't like that

P. Who wasn't like that.

T. Anybody else who knew you really and dump you.

P. I suppose some of the neighbours from when I was little, I mean I was quite surprised they didn't, well they weren't able to stick up for me when all the terrible things were going on when

I was at home but once I'd left home and I still see some of them now, and they sort of say well we knew what a terrible time you were going through. So they they stick up for me, at least they still want to know me but they don't see me very often you see.

T. Why is that, why don't they see you very often. Is it because they don't like you

P. They live quite a long way away

T. Right, so it's because they live a long way away. Anybody else really, other than your neighbours who knew you and didn't dump you.

P. Everybody has dumped me at some point. Even people who are around now at some point in the past dumped me. I mean this bloke who was going to come and do the decorating on Thursday, he dumped me when I came in here.

T. Right. OK.

P. I suppose he's come back again.

T. He's come back again, why?

P. Well, to put it crudely as he says, he's always after my body and he hasn't got it and I don't intend him to have it but that's what he says but I suppose there must be more to it than that.

T. Mm, mm. Is there any evidence of this more to it than that.

P. I suppose he keeps in contact more or less somehow.

T. Do you have physical contact every time he comes round to see you.

P. Oh no, never, no

T. So you know, it's not as if he's, so any other reason why he keeps coming back to you then.

P. I dunno, but I always attract all the wrong sort of people 'cause he's very strange. I mean, he's done terrible things to me in the past, I don't know why I keep in contact with him, I think I only keep in contact with him 'cause he I dunno,

T. What sort of terrible things has he done to you?

P. Well like dumping me when I was in here, when I was, initially when I was in here, initially he had the keys to my flat and he stole some things, not big things but he took things from my flat that didn't belong to him.

T. Right. Yes

P. As I say he is a very strange, or I dunno, he's an odd sort of bloke. I seem to attract odd people.

T. I think we're moving on to a different theme now, let's stick to the original one, you know, whether it's true that once people got to know you, they dumped you invariably, ? some evidence it's not true of your neighbours.

P. You see part of me is trying to say now, everybody falls out from time to time even if there are friends they, will come back again.

T. Do you know anybody who doesn't fall out with friends.

P. Mm, yeah one or two I think.

T. Right. One or two out of

P. Quite a few. About 10 or something I suppose

T. About 10 people will never fall out with friends.

P. No, no, no, 1 or 2 would never fall out.

T. Right, not ever again, not ever you know, falling out. Uh huh. Right. Who are these people.

P. Who are they ? Although actually that's not true 'cause the other, one of the ones I was thinking never falls out with people, he's one of the people who's dumped me so he's obviously fallen out with me or I've fallen out with him, I don't know why or what's going on there.

T. Could you rephrase that in a more objective way by saying, you know, that's the only, that's the incident that I know is fallen out with people but you know, stops there doesn't it. You don't know whether he is fallen out with anybody else. Would that be a more objective statement about it, about the person?

P. I don't know. I mean all I know is that I don't know what I've done wrong and why he won't talk to me any more.

T. Right. Let's again stick to this theme about you know, do people invariably dump you. I know that your mother, your adopted mother and your own mother your biological mother they didn't get on very well with them, I haven't got the sense about how you got on with your adopted father. Now he did he take you.

P. Well he didn't want to adopt but he, when, the adopted mother dumped me, he, he took over my care in as much as he could, 'cause he was a very busy father and apparently I, I got away with murder with him, I was really looked after, spoilt a bit. Apparently I was the only one who was allowed to sit on his lap and all this sort of business.

T. Apparently, I mean you were told you don't remember that.

P. Yes.

T. Uh huh.

P. and um, he was killed when I was eight so he went too.

T. Yeah. Right. Well you could construe it as you know was a let down, he was killed, you know, but um people do die and people do get killed, not because they intentionally so you know my feeling is we would probably be pushing it a bit too far to say he sort of dumped you

P. No, no, I sort, I appreciate that. Of course I do but it's just

T. So would he be another exception then.

P. Yeah but you see I don't know how horrible I was then, I suppose I was pretty horrible.

T. Why, if you didn't know that you were pretty horrible why do you think you suppose you were pretty horrible.

P. 'cause nobody else wanted to know me.

T. So you must be terrible then.

P. There must be some reason why they didn't want to know me.

T. Any, so, nobody else wanted to know you at that point.

P. No that's not true, I mean, our housekeeper used to look after me.

T. Who were everybody else then

P. Well the family

T. Right, so you are talking about your mother who, you know, you told me last time she just, somehow you know, adopted you because she started the machinery going and once she got her own then she just felt, you know, you were just bother and then the two brothers you had, you know, they were pretty nasty to you.

P. Well one wasn't, one was alright, the other one was horrible.

T. So one was alright. So we sort of mention about you know, presumably at that sort of age, you weren't very good at hiding, you know, you, these were family close, people close to you so these were the people who knew you. So we mention about your father, your mother, two brothers and a housekeeper. Out of five people, three were pretty good to you.

P. It didn't feel like that

T. I knew, I knew it didn't feel like that. That's the model when one's is depressed one tends to select negative bits out to go along with the negative moods, just like when I asked you you know, if you weren't how come you know, you didn't know whether you were pretty awful or not, how come you, you were quite sure that because people didn't want to know you that you must be pretty awful and yet when you look at the evidence it wasn't really quite like that.

P. But they, I suppose the, the overpowering theme was around was all this hate towards me.

T. Sure, yes, sure, I accept that. It's just you know, let's stick to the theme that you know, the whole idea of doing cognitive therapy is to be able to step back a bit to doubt and look for evidence like what we did just now, see, so what we did now was just to identify the negative thoughts going through your mind, so summarising what we talk about, you know, (tape ran out) 'because if you believe in those 80% therefore, you know, you were feeling sad you know, pretty, pretty depressed saying that 60% and so that demonstrated the ideal thinking and mood. There is another thing I wanted to throw in really. There is such a thing called emotional reasoning, now when somebody is depressed, the the trap that people often fall into is because I feel it, it must be true. That's what we call emotional reasoning. Because I feel that you know, once people got to know me they invariably dump me. It must be true because I feel that and yet when we look at the objective evidence, you know, it wasn't true, you know there were people, significant people in your life you know, who weren't like that. So we need to do a lot more than we do today in order to get into the model but you know that's that gist of it you know, sort of use it to illustrate what happen. So it might be a good idea, Jenny, to to some exercise really. I don't know whether this technique is familiar with you, you know, this is, this sort of day sort of we have an idea of how frequent, you know, what you get it, the emotion how we feeling at that point so just use the sample you gave me, you were depressed, yeah, that was 60%. OK. How bad was it. Situation, what were you doing or thinking about so you were thinking about the incident with two colleagues, do you want to call them colleagues or friends? Feeling I've said something stupid and make myself open and vulnerable. Is that a fair description you think. Now what sort of thoughts were going through your mind so you have things like um, why did I say that, what do they think of me, I'm inferior to them, would Linda ever contact me again, I presume, would it be fair to say at that point, the answer is no, that she wouldn't.

P. Yeah, I suppose so.

T. Probably not. So you believe ideally be nice to range each thought individually but you believe in that 60%, yeah. Let's stop here, what we need to do is to collect more, so that was Thursday last week, um, which was the 3rd, do you think it would be alright for you to collect more information, you know we've got a sense of the theme, why you get upset but it would be nice to collect more information so that we can work on these things.

P. Things that are going to happen between now and Monday

T. Next week, yeah, things that upset you, what sort of thoughts go through your mind, how much do you believe in it you know, how much that made you feel whatever emotion you were feeling at that point. Would that be OK.

P. Yeah

T. So if I supply you with some of these, OK, and then we can look at these two sections later on once we've got more information. We spent quite a bit of time on, on the um, the first thing on the agenda was you know, the feeling dreadful and yeah, the feedback, the feedback I don't understand how the feedback ties to that.

P. You don't

T. No I don't. The feedback of last session.

P. Oh I see, yeah. I suppose it was as, I suppose

T. Do you feel

P. I suppose the feedback of the last session was the fact that it it broke down the barrier and it made me think and I must, must admit that to begin with I was very reluctant um, not while I was here but I, it it's it's this anger that's around that says why do I have to do this, although the other part of me says you want to do this 'cause you don't wanna go on like this, so this, this, this internal struggle

T. Right. Yes. Yes. Right and then that explains why you were driving in your car and said I can't stand any more, I want to get this over and done with.

P. Mm

T. Can't stand this any more presumably sort of encapsulates your feeling of I can't stand how I feel at the moment and also you can't stand that you know, you have to go through this.

P. Yeah, although you see, I want to 'cause I don't wanna go on like this.

T. OK. Right. OK. Right. Anything else you want to tell me about you know, what you feel about the last session on the whole or we can move on if you

P. No, I suppose the overall feeling is what you said, glad I got going on it.

T. Right. OK. I'm pleased you know if that's the case, you know, I'm certainly pleased for you, you know, wanting to confront these feelings. Um, shall we look at these schedules. You were saying that you couldn't understand the concept of

P. It was just this mastery of, I mean I take it that it meant how, how much did I feel I'd achieved by it.

T. Yes

P. Is that right?

T. That's right. Accomplishment, achievement

P. How much effort did it take to do it.

T. Er, there is a slight distinction between how much effort it take, you might have to use, put in a lot of effort to do something, that's fairly straightforward because of you're depressed at the moment, on the other hand you might not put in, you might not have to put in a lot of effort but you achieve something, so, it's a sense of how much sense of achievement or accomplishment you get out of doing it. For example, decorating you know, you might rate it at 75% last week as you've done, putting a lot of effort in doing it.

P. Yeah

T. And doing another piece of house chore that you haven't done for a long time, you just couldn't you know, get yourself together to do it and yet the effort is not very much and yet you managed to achieve something that you've been dreading doing but once you started doing it it didn't seem to be much effort and therefore you didn't have to put in that much effort. And you might equally get 75% mastery out of that, you see what I mean. That's what we mean by you know, sense of accomplishment really, sense of achievement, how much you have achieved. Yeah. Does that make sense to you.

P. Yeah, yeah that's about what I thought it was

T. Do it, yes. So look as if you know your days were pretty full by looking at this.

P. Yeah, not watching television, not lying around in bed.

T. Right. Sorry, you watch a lot of television, um lying around in bed

P. Lying around in bed, just wandering around doing nothing

T. What's this POMO

P. Pleasure and mastery

T. Oh sorry, right, yes sort of lying around in bed, right. Is that a problem

P. Yeah it is sometimes. There is no reason to get up this morning.

T. OK. Right. Right. Just looking at it you know, you seem to be at the moment getting a lot of, you know, for some thing you get mastery, the mastery rating is higher than decorating than the pressure is so far is at it. Looking even at the highest rating of decorating is 50% pleasure. Most of the time you know its um mastery more than that, isn't it? Right.

P. Well usually, usually when I get on and do something, I feel pleased that I've done it

T. That's the mastery comes into it but

P. But, but I don't necessarily enjoy it and it takes hell of a lot of effort to do sort of most things

T. Sure, yeah. I think that's the the trouble with depression is when a person is depressed you know, the person who's tired, I don't know if that's your sense, lack of energy, and um, the more they feel like that the more they feel less inclined to do things, just just tired and partly also because you know when one's depressed one doesn't get that much pleasure out of things that one used to enjoy. So when a person is depressed the more one does, the more one gets less depressed. A sort of a paradoxical really, um, partly because you know when you are depressed and when you are lying in bed perhaps these negative thoughts just come popping

into your head and make you feel more depressed whereas when you start doing things that take things off your mind a bit, that for some people help.

P. But then you see I also, and, this morning a lot of what I was thinking about was, Steve came round last night unexpectedly, yesterday afternoon, not for long 'cause he was on his way somewhere, and I was mulling over what had been said and what it all meant and all of this sort of thing and I see him again tonight, at class, but,

T. Yes, or put it down on the thought record you know, what sort of thoughts going through your mind after you seen him and let's see whether there's any relationship between how you think and how you feel. And then the next step you know, is to look at evidence and master the technique of cognitive therapy. Yeah. So would you mind sort of keeping further records of the activity schedule so that we get some ideas of what happens, and if, if getting up in the morning is a problem then perhaps we can start looking at it, yeah? That would again collect data for us to work on in a session. Is that alright. So, right, um, if I could just take one unless you want to keep it. You got more of these haven't you

P. No I haven't

T. OK. Right. We have been in a sense touched on a bit about the, let's see if I got any more, we have in a sense touched on the um, um,

P. Yes I do, 'cause I'll be back on Monday won't I. Monday, 3rd?

T. Alright. The, I'm just sort of thinking you know, the last item on the list is you know, not able to say to people what I want to say, regretting it after. We have somehow touched a bit on that, slightly you know, sort of your two friends and two colleagues whatever you call them. I'm sorry do you know we don't seem to have enough time to go into that in detail but it's looks to me as if it is a thing that will come up again and again so you know, we will pick it up another time.

P. Perhaps we can start with it next week

T. OK. Why don't we do that. Alright. So, do you want to have a go at summarising what we said today.

P. Oh golly. You see this is where I panic and my mind goes a blank.

T. Why do you think your mind, what are you thinking at the moment.

P. I just can't remember what happ, what's happened and yet I know once I go away from here and in my own quiet, it'll all come back to me and this isn't something that just happens here it's happens all the way through my life. It's the fear of am I gonna be wrong am I gonna get it right, what's he gonna think.

T. These are negative thoughts aren't they, coming into your mind, am I going to get it right, am I going to get it wrong, what's he going to think of me, what do you think I was thinking when you know, when asked you to summarise.

P. It's almost as though I've been put on the spot and I don't know what to say.

T. Why do you think I want to do that?

P. Well, well no reason other than to help me to have it clear in my head what we've gone through so I can go away and take the thoughts with me. I mean they will go with me, they won't be lost but they're lost at this moment.

T. Sure. If you have this thought you know, about what would you think of me, am I going to do right, am I going to do it wrong, of course your mind would go blank wouldn't it? There's no right or wrong Jenny you know

P. I know, I tell myself that

T. Sure, yes, yes, there's no right or wrong, there's just everybody. I tell you what if I summarise, do you think I remember it all, do you think I get it all right?

P. Well you'll remember more than I do 'cause you've got it written down.

T. Right, sure, yes. That helps me a bit. Even though, you know, I have got it written down, even though I could refer to my notes, you know, would I be right.

P. No, I mean you're miss things out probably or..

T. Have I missed things out in the past, have I misunderstood you then you corrected me. This session or last session. You filled in the details, for example, when I was talking to you about your Thursday night you know.

P. Rather than correct, I'd say clarify.

T. That's the whole idea in fact, you got it. The word is clarify, you know, the idea of summarising is to clarify that you know we both got what was said. And you know um,

P. I suppose, alright then so we've talked about mainly about what happened between last session up until Monday and about how I felt and what the feelings were and um, how I could perhaps think about them differently and perhaps you know, there's actual um, truth in fact in how I was feeling or thinking and that perhaps I could think about it differently

T. And looking for evidence for or against, it's not just thinking you know, I think the idea of the model is, you demonstrates the relationship between thinking and emotion and look at you know, where is the evidence of me thinking that way is correct, so really it's the looking for evidence really.

P. Right. And then just touched on the feedback which really wasn't a lot and then um, going through this

T. Right so there's, yeah, two pieces of homework isn't it. One you have to continue with the activity schedule and you know if the getting up in the morning is a problem we'll you know deal with it and the other one is to start the thought record recording. Yeah. You summarised pretty well. You know.

P. But initially my mind was a blank.

T. Again demonstrated you know that's why. You know you thought I was going to judge you and of course you went blank. OK. So we must finish now, is there anything else that you think we ought to talk about.

P. No, not really.

T. Ok. Let's end there.

APPENDIX VII

Published Article* derived from Pilot Study

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Transference: An Empirical Investigation Across a Range of Cognitive-Behavioural and Psychoanalytic Therapies

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The reported study investigated transference across a range of cognitive-behavioural and psychoanalytic therapies. A conceptual analysis of transference definitions identified eight key components which were then utilized to construct an instrument for coding patient and therapist statements. The instrument coded verbatim transcriptions of 40 therapy sessions drawn equally from each of two cognitive-behavioural and two psychoanalytic therapies. The results showed transference references in both cognitive-behavioural and psychoanalytic therapies; but these references were significantly lower in cognitive-behavioural therapies, and psychoanalytic therapies were considered the context *par excellence* of transference. Therapists in psychoanalytic therapies made a higher number of transference statements and responded more fully to patient references to the therapist. It is suggested that transference does not lessen in cognitive-behavioural therapies if it is not acknowledged or recognized. There was an increase in explicit transference references in late over early sessions of all therapies. The implications of the study's findings are discussed with respect to the resolution of transference, and to patient noncompliance in cognitive-behavioural therapies.

INTRODUCTION

The concept of transference, wherein unconscious aspects of a patient's early relationship to parental figures is lived out with a therapist rather than remembered, was introduced into psychology by Freud (1895) 100 years ago. Initially Freud considered transference a nuisance phenomenon that interfered with therapy but over time came to see it played 'a part scarcely to be overestimated in the dynamics of the process of cure' (1923, p. 247). Psychodynamic therapies have continued to consider transference as inexorably a part of the patient–therapist relationship and this relationship as the primary vehicle of change; 'the single most important precondition to success' (Waterhouse and Strupp, 1984, p. 77).

Other therapies however see the patient–therapist relationship as less pivotal. Morris and Magrath (1983) from a review of the patient–therapist relationship in behaviour therapy concluded that the relationship, unless there was treatment noncompliance, did not significantly influence treatment outcome. Even in the case of

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noncompliance Wachtel (1982) argued, few behaviour therapists utilized psychoanalytical concepts, although as Freud (1912) had argued '... transference emerges as the most powerful resistance to (the) treatment' (p. 103).

Whilst behaviour therapy does not consider noncompliance a source of learning and change, some cognitive therapists have now begun to explore the patient–therapist relationship and may utilize noncompliance to uncover faulty assumptions (e.g. Safran and Segal, 1990). However, as Power (1989) noted, cognitive therapy offers no substantive theoretical framework from which to tackle core assumptions. Transference has no more been considered in cognitive therapy than behaviour therapy even though the views of cognitive theorists such as Guidano and Liotti (1983) exemplify that a cognitive model of transference is clearly feasible (*cf.* Mallinger, 1974).

But what is meant by transference? Although Freud attempted to maintain a unitary theoretical structure for psychoanalysis, both in his lifetime and subsequently a theoretical pluralism developed and with it a heterogeneity about the concept of transference: a heterogeneity not only across schools of psychoanalysis (e.g. Freudian and Kleinian) but also within particular theorists' views across time (e.g. Freud himself).

One framework for considering this heterogeneity about transference may be provided by considering the three 'groups' of British psychoanalysis i.e. Freudian, Kleinian and Independent; the latter being predominantly Object Relations.

ON FREUD, KLEIN AND OBJECT RELATIONS THEORY AND TRANSFERENCE

The term transference was first used in *Studies on Hysteria* (1895) which Freud co-authored with Breuer. Breuer was so shocked by a female patient, Anna O, falling in love with him that he stopped treating her. Freud, however, decided to study the phenomenon and utilized the term transference to describe what he saw as the false connection between a person who was an object of earlier wishes and the person of the analyst. In 1883 when Freud and Breuer first discussed Anna O they saw transference as an obstacle to therapeutic work. But by 1895 when *Studies on Hysteria* was published Freud considered the obstacle could be overcome by making the patient conscious of the false connection. He also saw a role for using patients' positive transference to cajole them into overcoming resistance to recalling painful memories from the past.

Freud had acknowledged that patients may hold not only extreme positive but also extreme negative feelings toward the analyst. It was not, however, until his Dora case in *Fragment of an Analysis of a Case of Hysteria* (1905) that he acknowledged the importance of these negative feelings. The centrality of Dora's negative transference and her harsh and premature termination of her analysis required Freud to revise his view of transference. He now considered it a form of resistance, in which the patient used either seduction or hostility to impede the exploration of the past *and* in addition re-enacted a specific previous relationship.

In *The Dynamics of Transference* (1912) Freud argued that repressed infantile longings and negative feelings were re-enacted with the therapist rather than remembered. In *Beyond the Pleasure Principle* (1920) he considered this repetition a consequence of the 'compulsion to repeat', which was repeated either (i) because of a self destructive wish or (ii) to master an old traumatic situation. In *The Question of Lay Analysis* (1926) he argued that transference allowed a reconstruction of infantile feelings thereby revealing the 'kernel of intimate life history'.

The classical Freudian view of transference is therefore of displacement (*cf.* Laplanche and Pontalis, 1988); feelings properly belonging to an earlier relationship become focused on the analyst. The analyst's task is to help patients identify conflicts expressed in the transference and refine their knowledge of the origin of these conflicts and the way they distort contemporary relationships.

Freud's revision of transference, though necessitated by his experience with Dora, cannot however be fully explained by that experience; thus, if Dora's transference was a re-enactment of a previous relationship in which she was rejected why with Freud was the one who did the rejecting? It was clear therefore that transference was not a straightforward historical re-enactment of an earlier relationship. Subsequent development of the concept of transference by Klein provided a supplementary explanation. Transference was an enactment of current phantasy, derived from difficulties encountered in the analytic situation and moulded upon earlier life experiences.

The Kleinian view of transference considers the analyst a receptacle into which internal figures and the anxiety surrounding them are projected (Segal, 1981). Klein (1952) is explicit that projection is at the

foundation of mental functioning and that every utterance in the patient–analyst interaction has transference implications. In contrast, Freudian analysts would more usually require an accumulation of utterances to present converging evidence of transference material. The mutative process in Freudian analysis is through increased knowledge becoming available to the ego ('where id was, there shall ego be'). In Kleinian analysis it is through repairing 'splits', in which the therapist's interpretations feed back to the patient projected elements of the self.

Some drive theorists such as Kernberg (1976) and Sandler (Sandler and Sandler, 1978) whilst retaining classical metapsychological language have given increasing weight to the premises of Object Relations theory. Object Relations theorists (e.g. Winnicott, 1965; Fairbairn, 1978) emphasize the need to form and maintain relationships in the place on sexual and aggressive drives in explaining how people interact with the world. Transference is considered to arise from mental representations of the self and others. These representations are derived from early relationships (Balint, 1968) and serve to organize recurrent affective–cognitive experiences. In considering the mutative process, Object Relations theorists place less emphasis than drive theorists on the information giving function of transference interpretation and more emphasis on the need to provide a safe and caring environment, a 'genuine emotional contact' (Fairbairn, 1978) providing what may have been missing in early life.

SUMMARY OF THE CONCEPTUAL DIVERSITY OF TRANSFERENCE

In summary, rather than being a unitary concept transference may be seen as '... several concepts that have unfolded over the course of more than a century' (Hinshelwood, 1990): namely, (i) an unwanted event; (ii) something the analyst may use to overcome the patient's resistances to psychoanalytic exploration; (iii) a form of resistance used by the patient to inhibit the psychoanalytic process; (iv) a re-enactment of a previous relationship allowing reconstruction of childhood history; (v) an enactment of current unconscious phantasy stimulated by the difficulties of the analytic session; (vi) an enactment with the analyst of internal object relations.

In view of this apparent conceptual diversity any empirical investigation of transference needs to state explicitly its defining characteristics.

PREVIOUS RESEARCH

Research on transference may be seen to have moved through three stages. In the first stage parent–therapist similarity, as perceived by the patient, was considered to be evidence of transference (e.g. Chance, 1952; Crisp, 1964). Whilst not without value, this is an unsophisticated view of transference. In addition the methodologies used studied transference outside of the patient–therapist relationship in which it is expressed.

In the second stage, studies investigated the degree to which independent judges agreed on the presence of transference, predominantly in audio-taped therapy sessions (e.g. Luborsky *et al.*, 1973). Olsson (1988) argued that the low degree of agreement on transference ratings in such studies suggested a need for more concretely defined common criteria for transference and judges trained in the use of the rating instrument.

In the third most recent stage, measures have been developed which appear the closest yet to the clinical concept of transference. For example, Gill's coding system 'The Patient's Experience of the Relationship with the Therapist' (PERT) (Gill and Hoffman, 1982) rates the frequency of communications regarding the patient's experiences of the relationship with the therapist. The communications rated must meet stringent criteria and no attempt is made to consider the content of communications. Luborsky has developed 'The Core Conflictual Relationship Theme' (CCRT) (Luborsky *et al.*, 1986) which rates the content as well as the frequency of statements. However the only statements rated are those made by patients in which they describe interactions with one main person toward whom they express wishes, needs and intentions. Luborsky (1990) provides substantial empirical support for the validity of CCRT. However the system is not without problems; thus not all patient interactions can be characterized by wishes, needs or intentions and transferential material is not solely expressed within narratives about interactions with one main person.

There is a need therefore for a transference coding system that may be applied to verbatim transcriptions of actual therapy sessions, which has clearly defined components and is manualized, and which may be applied to all utterances within sessions. In addressing this need and given the conceptual diversity of transference the authors began by attempting to reach an operational definition of transference. They did this by undertaking a conceptual analysis which aimed to

Table 1. Conceptual analysis

'Primitives'	Frequency	Percentage of sample
Conflict	17	39
Inappropriateness	23	52
Past		
(i) Childhood	26	59
(ii) Other past	14	32
Parent	6	14
Past sig. other	5	11
Therapist	35	80
Lack of awareness	23	52
Attitude	13	30
Behaviour	9	20
Feeling	22	50
Thought/idea/memory	21	48
Wish/impulse	8	18
Fantasy/phantasy	9	20
Instinct	0	0

identify the shared elements used in definitions of transference.

CONCEPTUAL ANALYSIS OF TRANSFERENCE

A literature search identified 44 definitions of transference (a complete list is available from the authors). A conceptual analysis of these definitions identified 14 'primitives' (see Table 1).

The concept of a 'primitive' is analogous to the idea of a 'semantic primitive', identifiable in conceptual analyses of lexical terms. Thus, for example, Miller and Johnson-Laird (1976) argue that the concept 'red' is a semantic primitive because it cannot be usefully further semantically divided. By analogy therefore it is argued that terms such as 'therapist', 'parent', 'feeling', and 'conflict' are basic concepts in the analysis of definitions of transference.

The frequencies of 'primitives' identified from the conceptual analysis of transference are identified in Table 1 and outlined in the following points.

Conflict

A conflictual origin to transference, internal or external, was referred to in 39% of definitions. References to concepts such as 'unconscious' and 'repressed' were taken to imply a conflictual basis.

Inappropriateness

Fifty-two per cent of definitions indicated that the transference was not fully appropriate. A number, however, indicated that the therapist may stimulate certain transferences, for example, Freud (1905) '... taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that' (p. 157).

Derived From the Past

Transference was seen to be rooted in the past in 77% of definitions and 59% of these referred to childhood origins.

Derived From Relationship with Parents

Fourteen per cent of definitions explicitly referred to transference being derived from relationships with parents. Another 11% referred to relationships with significant childhood figures.

Refers to Therapist

Eighty per cent of definitions referred to transference occurring toward the therapist, 31% mentioned transference toward current significant others.

Lack of Awareness

A lack of awareness, by the patient, of transference was stated by 52% of definitions.

What is Transferred

Thirty per cent of definitions referred to the transfer of earlier **attitudes** to the present, 20% to the transfer of **behaviour**, 50% of feelings, 48% of **thoughts/ideas/memories**, 18% of **wishes/impulses** and **20% of fantasies (or phantasies)**.

Thus although theoretical pluralism in psychoanalysis has led to a heterogeneity about the concept of transference the conceptual analysis suggested agreement that patients re-experience with the therapist interpersonal styles that are derived from childhood relationships with primary caretakers. Over a third of definitions identified the conflictual nature of these relationships. Whilst the therapist was identified as a recipient of transference, others were not excluded as potential recipients. Approximately half the definitions considered that transference was not wholly appropriate and that the patient was not fully aware of it. Attitudes, behaviour, feelings, fantasies, ideas, impulses, memories, thoughts and wishes were identified as being transferred.

Table 2. Transference coding system

	Explicit	Implicit
Reference to therapist or therapy	1e	1i
Reference to past significant other (other than primary caretaker)	2e	2i
Reference to caretaker (usually parent)	3e	3i
Reference to current feeling/thought/ behaviour/attitude etc.	4e	4i
Reference to past feeling/thought/ behaviour/attitude	5e	5i
Reference to childhood feeling/thought behaviour/attitude	6e	6i
Reference to interpersonal or intrapersonal conflict	7e	7i

THE TRANSFERENCE CODING SYSTEM

From the conceptual 'primitives' that were identified, a system for coding narratives, listing seven transference components was drawn up. An eighth component referred to the lack of awareness by the patient of the transferential aspects of their relationship with the therapist. The coding system, presented in Table 2, therefore identified each of the seven listed components as potentially explicit or implicit; implicit references to components needing to be inferred by the rater. For example if we consider the statement by a patient 'When I went to confession yesterday I thought that the priest must get overladen with peoples' problems. Afterwards I felt guilty about it'. The statement refers explicitly to a current feeling involving the priest. The rater may also infer that the reference to the priest and confession is an implicit reference to the therapist and therapy.

The majority of transference definitions that referred to the past referred specifically to childhood and to experiences involving primary caretakers rather than, more generally, past significant others. Therefore references about past, but not childhood, feelings were excluded as were references to past significant others who were not primary caretakers. As a result an abbreviated version of the coding system was produced with a tally of codes (see Table 2) 1e, 3e, 4e, 6e and 7e which measured explicit transference and 1i, 3i, 4i, 6i and 7i which measured implicit transference.

A preliminary investigation rated verbatim transcriptions of a range of cognitive-behavioural, cognitive and psychodynamic therapies in order to provide general guidelines on rating statements and to identify criteria for assigning codes in unclear cases. These guidelines stressed that each statement was to be rated separately i.e. without reference to preceding or subsequent statements, for explicit and implicit references to transference components.

The transference coding system is applied by way of example to the following sample statements by patients:

I feel happy.	4e
I felt happy after the last session.	1e 4e
I am beginning to question the way we talk about things.	1e 4e 7e
I am furious you kept me waiting. You are just like my father. You don't care about me, it's just a job to you.	1e 3e 4e 7e
I have never trusted authority figures after the way my parents treated me as a kid. I used to wish them dead.	1i 3e 4e 6e 7e

and statements by therapists:

Perhaps it's not just you're teachers at school that you're angry with.	1i 4e 7e
I think you feel angry with me too.	1e 4e 7e
I think you feel angry with me. Perhaps since an infant you have felt like that toward people you think should look after you.	1e 3i 4e 6e 7e

RELIABILITY OF TRANSCRIPTION RATINGS

One hundred patient statements each paired with the therapist's response to them were taken from across the four groups in the study reported here. The statements, previously rated by the first author, and exhibiting a wide range of codings, were then rated by an independent rater, who was trained in the use of the coding system.

The transference coding system showed good reliability with a high percentage agreement between raters obtained on all components of the coding system, explicit and implicit. The percentage agreements are presented in Table 3.

Psychoanalysis operates within a different paradigm to empirical psychology and traditionally has relied on clinical case study to advance rather than an empirical route. From Freud (1920) to the present day it has repeatedly rejected challenges (*cf.* Grunbaum, 1984) to its scientific basis. These

Table 3. Percentage agreement between raters on components of the transference coding system

Components	Code	Explicit	Implicit
Reference to therapist or therapy	(1)	94	75
Reference to caretaker (usually parent)	(3)	99	97
Reference to current feeling/ thought/behaviour/ attitude etc.	(4)	82	82
Reference to childhood feeling/ thought/behaviour/ attitude etc.	(6)	99	91
Reference to interpersonal or intrapersonal conflict	(7)	90	84

challenges arise because its database sets it apart from the objectively verifiable data demanded by the physical sciences; for although psychoanalysis does deal in part with objective data it is defined by its subjective investigation of private experience. Analysts use their own introspections, finely tuned by personal analysis and training, to vicariously introspect their analysands' psyches. Truly psychoanalytic data must include subjective data.

We have therefore had to face methodological problems in developing a reliable and valid measure of transference. As observers outside of the consulting room, we cannot directly access the subjective dataset available to the therapist and therefore lose some of the richness of the transferential relationship. We can only directly access the objective manifestations of patients' transference and therapists responses to it. Nonetheless we have developed a manualized instrument which can go beneath the immediate content of patients' and therapists' utterances and reliably rate their implicit content.

THE PRESENT STUDY

In the present study the authors used the coding system to analyse verbatim transcriptions of taped cognitive-behavioural, cognitive and psychodynamic therapy sessions. Both patient and therapist utterances were analysed.

It was hypothesized that references to transference components would occur in all the therapies but that psychoanalytic therapists would respond more often to such statements with transference references than would therapists in other therapies. It was therefore expected that explicit references to transference components would occur less in cognitive-behavioural and cognitive therapies because their presentation would not be commented on. It was also hypothesized that references to transference components would occur with equal frequency in late as in early sessions of psychodynamic therapy but that implicit references would occur less frequently because one objective of the psychoanalytic therapist is to make implicit material explicit.

METHOD

Participants

Five therapists participated in the study. All were highly experienced clinical psychologists with recognized expertise in their field of work. Therapist A was a District Psychologist and qualified adult psychoanalytic psychotherapist. Therapist B was an experienced cognitive therapist, supervised on all sessions by a clinical psychologist trained at the Center for Cognitive Therapy, Philadelphia and he himself had completed training there. Therapists C, D and E all had international reputations from their research work on psychotherapy. To ensure adherence to treatment protocols all underwent manualized training and weekly peer and individual supervision, before and during treatment sessions analysed in the present study. Adherence to protocol was also confirmed by checking verbal-response mode usage of therapists (Hardy and Shapiro, 1985).

Audiotaped and videotaped sessions of 19 patients were utilized. Demographic and diagnostic data on these participants were not sought. All were adults who appeared to be suffering from relationship difficulties, anxiety and/or depression.

Design

The research utilized a mixed between subjects and within subjects design.

It must be noted that the unit of analysis used in this study was the particular therapist–patient pair, rather than the specific therapist or the patient. For this unit of analysis there was one between subjects factor, the type of therapy, for which there were four levels, and one within subject factor, session number, for which there were two levels (early or late). The four levels of the type of therapy factor were: group 1—cognitive therapy, group 2—cognitive-behavioural therapy, group 3—Hobson's conversational therapy and group 4—short term focal psychoanalytic therapy. If therapies are considered separately, then, group 1 consisted of therapist B

and two sessions of each of five patients; group 2 of therapists C and D and two sessions of each of five patients; group 3 of therapists C and E and two sessions of each of five patients; and group 4 of therapist A with two sessions of each of three patients and four sessions of one patient. Thus there were 10 sessions, five early and five late, in each of the four groups.

The interventions of all four groups were of between 10 and 16 sessions.

The Therapies

Group 1: Cognitive Therapy

This method, based on Beck's (Beck *et al.*, 1979) model of cognitive therapy, views psychological difficulties as frequently resulting from habitual errors in thinking. Therapy aims to restructure dysfunctional cognitions, through for example eliciting and challenging negative automatic thoughts, and behavioural experiments. The patient and therapist work collaboratively to relieve symptoms and learn more effective ways of dealing with the patient's difficulties. Sessions typically focus on the here and now and how problems are maintained, rather than the origin of these problems.

Group 2: Cognitive-Behavioural Therapy

This method (see Shapiro and Firth, 1987) focuses on patient behaviour outside of sessions and the provision by the therapist of self-management strategies for application by the patient. These strategies include: anxiety control training (Snaith, 1974), self management procedures (Goldfried and Merbaum, 1973), cognitive restructuring (Beck *et al.*, 1979), and a 'job strain' package (Hackman and Suttle, 1977) to reduce stress at work.

Group 3: Conversational Therapy

This method (see Shapiro and Firth, 1987), based on Hobson's (1985) Conversational Model, assumes patients' problems arise from disturbed significant personal relationships. It aims to create a patient–therapist relationship within which interpersonal problems are revealed, explored, understood and resolved. The therapist focuses on the experience of the patient in therapy and makes connections between this and other experiences of the patient, suggesting reasons for the patient's experiences and behaviour.

Group 4: Short Term Psychoanalytic Therapy

This method (see for example Malan, 1976) focuses on bringing into consciousness unconscious conflicts thought to underlie the patient's problems. These conflicts are considered to be re-enacted in the transferential patient–therapist relationship. The therapist early in treatment identifies the patient's core conflict and focuses on this, interpreting signs of it and its past origins in the patient's manifest behaviour, particularly that displayed in sessions. This knowledge is considered to facilitate the patient gaining mastery over the conflict.

Procedure

Detailed verbatim transcriptions, including paralinguistics, made of the 40 taped sessions used in the study. All patient and therapist statements in each transcription were analysed using the transference coding system, and the codings annotated in the transcription margin. These codes were then transferred to a coding sheet.

RESULTS

Results are presented first in which the main effect analysed was the type of therapy and which address the presence of transference referents across the range of psychotherapies. These analyses examine the references made, both explicitly and implicitly, by patients and by therapists to individual transference components. They also examine the linking of transference components within statements. In the second set of results presented the main effect analysed was session order, that is these analyses consider any variation in transference references between sessions early in therapy and those at the end of therapy.

Data were analysed using SPSSPC Version 3.1.

The Presence of Transference Referents Across Therapies

Patient Statements—Individual Transference Components

The percentage of statements by patients, across the four groups, in which each of the 10 potential transference components were identified are presented in Table 4.

Explicit Patient References. There was a significant variation across therapies in the number of explicit references made by patients about parents ($F(3,36) = 18.12$, $p < 0.001$), therapists ($F(3,36) = p < 0.001$), and past feelings ($F(3,36) = 11.29$,

Table 4. Percentage of patient statements in which each of 10 transference components were identified

Group referent	Cognitive	Cognitive behaviour	Conversational	Psychoanalytic
Explicit reference to				
Therapist	6.20	4.00	13.30	31.40
Parent	3.00	2.40	7.30	25.30
Current feeling	57.80	54.70	69.30	62.00
Past feeling	3.20	0.90	4.40	17.00
Conflict	5.90	9.30	14.30	24.30
Implicit reference to				
Therapist	15.70	19.40	25.20	32.10
Parent	2.10	2.80	6.80	8.20
Current feeling	2.60	3.40	5.80	11.70
Past feeling	3.60	6.60	12.90	19.80
Conflict	5.00	5.80	7.70	17.40

Table 5. Percentage of therapist statements in which each of 10 transference components were identified

Group referent	Cognitive	Cognitive behaviour	Conversational	Psychoanalytic
Explicit reference to				
Therapist	4.60	1.70	14.00	28.30
Parent	1.60	2.20	4.30	25.00
Current feeling	46.00	54.00	67.70	59.40
Past feeling	0.10	2.00	4.10	15.30
Conflict	3.40	3.70	7.60	12.60
Implicit reference to				
Therapists	9.10	10.50	15.10	8.50
Parent	1.20	1.00	2.38	2.30
Current feeling	3.00	3.00	3.00	3.90
Past feeling	1.80	2.60	5.90	8.80
Conflict	2.90	3.10	7.40	15.90

$p<0.001$). Further analyses showed that more references were made about each of these transference components (Scheffe test, $p<0.001$, $p<0.05$, $p<0.05$ respectively) in the psychoanalytic group than in other groups which did not differ significantly from each other. There was also a significant variation across therapies in the number of references made about conflict ($F(3,36)=9.93$, $p<0.001$) with the psychoanalytic group making more references (Scheffe test, $p<0.05$) than the cognitive and cognitive-behavioural groups. There was no overall significant effect of type of therapy on references to current feelings.

Implicit Patient References. There was a significant variation across therapies in the number of implicit references made by patients about the therapist ($F(3,36)=5.35, p<0.05$), past feeling ($F(3,36)=12.45$, $p<0.001$), current feelings ($F(3,36)=5.88$, $p<0.05$), parents ($F(3,36)=4.10$, $p<0.05$) and conflict ($F(3,36)=15.10, p<0.001$). Further analyses showed more references were made about the therapist and about conflict (Scheffe test, $p<0.05$ and $p<0.001$ respectively) in the psychoanalytic group than other groups, which did not differ significantly from each other. Patients in the exploratory groups (psychoanalytic and conversational) made more references to current and past feelings (Scheffe, $p<0.05$ and $p<0.001$ respectively) than the prescriptive groups (cognitive and cognitive-behavioural).

Therapist Statements—Individual Transference Components

The percentage of statements by therapists, across the four groups, in which each of the 10 transference components were identified are presented in Table 5.

Explicit Therapist References. There was a significant variation across therapies in the number of explicit references made by therapists about themselves ($F=(3,36)=13.38$, $p<0.001$), parents ($F(3,36)=$

Table 6. The mean summated explicit and implicit references to transference components (past feeling, parent, current feeling, therapist) for each patient and therapist statement, excluding conflict

Group variable	Cognitive	Cognitive behaviour	Conversational	Psychoanalytic
Patient explicit	0.702	0.618	0.944	1.360
Patient implicit	0.321	0.243	0.508	0.691
Therapist explicit	0.552	0.575	0.904	1.276
Therapist implicit	0.161	0.171	0.283	0.226

Maximum possible mean summated score = 4.

24.32, $p<0.001$), past feelings ($F(3,36)=12.96$ $p<0.001$) and conflict ($F(3,36)=6.03$, $p<0.005$). Further analyses showed more references were made about therapists, parents and past feelings in the psychoanalytic group than in other groups (Scheffe test, $p<0.001$, $p<0.001$ and $p<0.001$ respectively), which did not differ significantly from each other. The psychoanalytic groups also contained more references to conflict than in the prescriptive groups (Scheffe test, $p<0.05$). There was no significant effect of type of therapy on references to current feelings ($f=2.35$, n.s.).

Implicit Therapist References. There was a significant variation across therapies in the number of implicit references made by therapists about past feelings ($F(3,36)=5.69$, $p<0.05$) and conflict ($F(3,36)=13.12$, $p<0.001$). Further analyses showed more references were made about past feelings and conflict in the psychoanalytic group than in prescriptive groups (Scheffe test, $p<0.05$ and $p<0.05$) respectively) which did not differ significantly from each other.

Patient and Therapist Statements—Summated Transference Components

The more transference components referred to in a statement the more clearly the statement would be transferential. The sum of the transference components in each patient and each therapist statement were therefore calculated excluding conflict. The mean of these by group are presented in Table 6.

There was a significant variation across therapies of the mean total of transference components referred to in the statements of both patients and therapists ($F(3,36)=13.30$, $p<0.0001$). Further analyses showed the psychoanalytic group to have a significantly higher rating than the prescriptive therapies in all but therapists' implicit references (Scheffe test, $p<0.001$). Analysis of implicit therapist statements showed no two groups to be significantly different.

Therapist Response to Patient Transference Statements

For each patient–therapist paired statement, the summated transference score of the therapist response was subtracted from the summated transference score of the patient. This indicated whether therapists' statements referred to more, less or the same number of transference components as the patient statements they were responding to. A score of '−4', for example, being obtained when the patient statement refers to no transference components and the therapist to four, and a score of '+4' when the patient statement refers to four transference components and the therapist none. To refer consistently to less may indicate a lack of therapist interest in, or awareness of, references made. To refer consistently to more may indicate therapist comments aimed at uncovering latent meaning in patient statements and making links with other experiences of the patient.

Table 7 presents a breakdown by percentage of the range of scores obtained derived from explicit transference references excluding conflict. Correlational analyses showed significant correlations (ranging from $r=0.38$, $p<0.01$ to $r=0.94$, $p<0.001$) between these scores and other subtracted transference scores.

The analysis of subtracted transference scores showed no overall significant effect of type of therapy ($F(3,36)=1.01$, n.s.). No groups had scores of '−4' or '+4' but the psychoanalytic group showed a trend towards a higher percentage of scores of value '−3', '−2' and '+2' than other groups and a lower percentage of subtracted transference scores of value '0'.

There was a significant effect of group in analysing therapists' response to patients' explicit ($F(3,36)=7.45$, $p<0.001$) and implicit ($F(3,36)=10.07$, $p<0.001$) references to them (see Table 8). Psychoanalytic therapists' made more transference references in response to such explicit (Scheffe test, $p<0.05$) and implicit (Scheffe test, $p<0.001$) references than therapists in other groups.

Table 7. Breakdown by percentage of subtracted transference scores of paired patient–therapist statements

Group score	Cognitive	Cognitive behaviour	Conversational	Psychoanalytic
–4	—	—	—	—
–3	0.07	—	0.44	2.50
–2	1.47	0.91	4.30	8.50
–1	21.30	22.20	16.70	21.30
0	56.32	50.39	48.46	29.82
+1	24.07	23.02	20.26	23.12
+2	3.22	1.94	5.28	10.59
+3	0.27	0.29	0.40	2.72
+4	—	—	—	—
Mean score	0.16	0.04	0.03	0.08

Table 8. Mean number of transference components in therapist responses (explicit) to patient references to the therapist

Group variables	Cognitive	Cognitive behaviour	Conversation.	Psychoanalytic	Potential max. score
Explicit patient reference to therapist	0.59	0.63	1.14	1.36	4
Implicit patient reference to therapist	0.63	0.65	1.06	1.39	4

Comparison of variables across early and late sessions

Early sessions were taken from the first five sessions of therapy and late sessions from the last five. Patients made more explicit references linking current and past feelings, parent and therapist in late compared with early sessions and this approached significance ($F(1,32) = 3.57$, $p < 0.068$). There was no significant effect of session order on the linking of patient implicit references or therapist explicit and implicit references.

Inspection of data suggested that therapists in all groups made more explicit transference references in late sessions of therapy than in early. The data also suggested that both patients and therapists in exploratory therapy made less implicit transference references in late sessions. Conversely patients in prescriptive therapy appeared to make more such references in late sessions. There was no difference across sessions in the frequency of implicit transference references made by prescriptive therapists. These results are presented in Table 9.

DISCUSSION

Although patients and therapists across all the therapies made references to transference components, these were significantly lower in prescriptive than in exploratory therapies. Patients in prescriptive therapies did make statements linking all transference components: the therapist, parent, past and current feelings and conflict. However these accounted for less than 1% of total statements in the cognitive therapy group and 2% of total statements in the cognitive-behavioural group. Nonetheless, these findings countered the view of some analysts (e.g. Waelder, 1956) that transference is peculiar to the analytic encounter and provided some support for the view that it pervades all therapeutic relationships.

The higher ratings of transference components in exploratory therapies, particularly psychoanalytic, provided support for the rationale presented by psychoanalytic therapists for refraining from personal disclosure and providing limited opportunities for patients to reality test about the relationship. This it is argued facilitates a transferential relationship in which the patient enacts interpersonal styles in relation to the therapist that are derived from conflictual childhood relationship.

Patients' Transference References

It had been hypothesized that patients in prescriptive therapies would make less references explicitly to transference components because their therapists would attend less to such references than would exploratory therapists. This was shown to be so. Inspection of data suggested that patients' implicit

Table 9. Mean summated references to transference components by group and session order

Group and session order	Patient implicit	Patient explicit	Therapist implicit	Therapist explicit
Cognitive				
Early	0.23	0.67	0.16	0.54
Late	0.25	0.73	0.16	0.56
Cognitive-beh.				
Early	0.31	0.58	0.17	0.54
Late	0.33	0.66	0.17	0.61
Conversation.				
Early	0.53	0.91	0.31	0.90
Late	0.49	0.98	0.26	0.91
Psychoanal.				
Early	0.73	1.23	0.26	1.15
Late	0.65	1.49	0.20	1.40

references about therapists were higher than their respective explicit references in cognitive, cognitive-behavioural and conversational therapies. This raises for consideration the possibility that explicit references about therapists were not facilitated in these groups, but sought expression nonetheless through implicit routes. It also raises for consideration the possibility that implicit references about therapy and the therapist are more frequent in psychological therapies than are usually acknowledged. If, as is likely, negative feelings about therapy are more usually expressed implicitly (*cf.* Gill and Hoffman, 1982), then early recognition of these may lessen the incidence of treatment noncompliance.

Therapists' Transference References

Psychoanalytic therapists made a significantly higher number of references to transference components than did conversational therapists and both, as hypothesized, made a significantly higher number of references than did their counterparts in prescriptive therapies. Exploratory therapists also made a significantly higher percentage of explicit references about themselves than did prescriptive therapists including in response to patients' explicit and implicit references about them. This provided support for a defining feature of exploratory therapies being exploration of the patient–therapist relationship.

Therapists in exploratory therapies responded more frequently and more fully to patient transference statements than therapists in the prescriptive therapies. There was no overall significant group effect in analyses based on therapists' mean summated transference scores subtracted from the scores of patient statements they were responding to. However, it is likely this reflects the high level of patient references to transference components in exploratory therapy.

Exploratory therapists, more often than prescriptive, responded to patients statements with significantly more or significantly less transference components than were in the patient statement. This suggested transference references are not always immediately responded to in exploratory therapies, for which there may be a variety of reasons. Some psychoanalysts for example consider interpretations should only be made when transference increases, is negative, and impedes the progress of treatment (*cf.* Luborsky *et al.*, 1979). Perhaps sound advice for prescriptive therapists. But the lack of an always immediate response is not surprising for another reason. In the consulting room contextual information such as previous utterances are important in construing the presence and nature of transference. This fact is true whether one is a Kleinian psychotherapist, for whom a single reference to a transference component may have transference implications, or whether one is a Freudian or Object Relations psychotherapist who requires accumulated references to components to provide evidence of transference. In the study reported here, raters were denied raters' access to contextual information such as previous statements. However, research currently being undertaken will manipulate the amount of such information to which raters have access.

Early and Late Sessions

In prescriptive therapies, as predicted, therapists seldom responded to patients' explicit references to

transference components. Despite this finding such references were more frequent in late than in early sessions. Patients' explicit references were also higher in late sessions of exploratory therapy. At first sight this may be seen to reflect the importance placed in exploratory therapies (*cf.* Graff and Luborsky, 1977) on interpreting the latent meaning of patients' experiences thereby making implicit material explicit. However support for there being a process in this group for the transfer of unconscious material to consciousness was not conclusive because although implicit transference did lessen it did not do so significantly. Furthermore, implicit references are not unequivocally unconscious but may include conscious but not directly expressed material, for example, negative feelings toward the therapist that may be difficult to express directly. A reduction in implicit references may therefore reflect conscious but indirect material being expressed more openly, perhaps within the context of an improving therapeutic alliance.

Consideration of the Differences Found Between the Conversational Therapy Group and the Short Term Psychoanalytic Therapy Group

Therapists in the conversational therapy group made significantly less references to transference components than their counterpart in the psychoanalytic group. In addition, although they made more transference references than prescriptive therapists, the differences were not significant. This finding is likely to be explained by the treatment focus of conversational therapy. In common with other exploratory therapies conversational therapy is based on the rationale that patients enact their problems within the patient–therapist relationship and that a mutative process occurs through exploration, understanding and re-adjustment of this relationship. But in contrast to the psychoanalytic group the focus of therapy is on what is happening in the present, with references less frequently made to the therapist and parent than to present significant others. References to past experiences are considered relevant only in so far as they promote a 'language of feeling' in the present.

Conclusions

The present study found support for the occurrence of transference references in both prescriptive and exploratory therapies. The frequency of these references however were markedly lower in prescriptive therapies, and exploratory therapies were considered the context *par excellence* of transference. Therapists in exploratory therapies, as hypothesized, made a higher number of transference statements and responded more fully to patients' references about the therapist.

Compared to other references, patients in prescriptive therapy made a high number of implicit references about the therapist. It is suggested that the prescriptive therapy analysed did not generally facilitate overt comment on the therapeutic relationship and therefore implicit comment was necessitated. Such inattention to interpersonal issues may potentially damage the therapeutic alliance and lead to treatment noncompliance. Prescriptive therapies would benefit from a theoretical framework within which to understand the 'intrusion' into treatment of resistance behaviour (e.g. Power, 1991). The exploration of such behaviour as it arises would also uncover aspects of patients' difficulties, not established during assessment, which may be ameliorated during treatment.

Patients' explicit transference references approached being significantly higher in late than in early sessions of prescriptive therapy. This finding suggests that transference is not extinguished if therapists do not acknowledge or recognize it. In the exploratory therapies this increase in explicit transference references was accompanied by a reduction in implicit references. Although this reduction did not achieve significance, it does provide some support for a process in exploratory therapies wherein the exploration, understanding and re-adjustment of the patient–therapist relationship facilitates the transfer of unconscious material (implicit transference) to consciousness (explicit transference) where there may be increased patient awareness and control of it. The level of transference in early sessions of therapy case doubt on the view held by some therapists that transference is little present in early psychotherapy sessions.

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APPENDIX VIII

RESULTS I

The Presence of Transference References in Early Sessions and in Late Sessions

1. Patient Explicit References

1.1 Percentage

1.1.1 Early Sessions

A series of one-way ANOVAs showed an overall effect of type of therapy in early sessions of the six therapy groups of the percentage of patient statements containing explicit references to the therapist ($F(5, 17) = 15.018$, $p<0.001$), parents ($F(5, 17) = 5.881 = p<0.005$) and conflict ($F(5, 17) = 4.190$, $p<0.05$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Behaviour ($t(17) = 3.153$, $p<0.01$), Cognitive-behaviour ($t(17) = 3.129$, $p<0.01$) and Cognitive ($t(17) = 2.515$, $p<0.05$) therapy groups; to parents than the Behaviour ($t(17) = 2.708$, $p<0.05$), Cognitive-behaviour ($t(17) = 3.321$, $p<0.005$), Cognitive ($t(17) = 3.076$, $p<0.01$) and Conversational ($t(17) = 2.511$, $p<0.05$) therapy groups; and to conflict than the Behaviour ($t(17) = 2.376$, $p<0.05$) and Cognitive ($t(17) = 2.227$, $p<0.05$) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Behaviour ($t(17) = 7.383$, $p<0.001$), Cognitive-behaviour ($t(17) = 7.686$, $p<0.001$), Cognitive ($t(17) = 7.056$, $p<0.001$) and Conversational ($t(17) = 6.195$, $p<0.001$) therapy groups; to parents than the Behaviour ($t(17) = 3.630$, $p<0.005$), Cognitive-behaviour ($t(17) = 4.151$, $p<0.001$), Cognitive ($t(17) = 3.949$, $p<0.001$) and Conversational ($t(17) = 3.501$, $p<0.005$) therapy groups; and conflict than the Behaviour ($t(17) = 3.875$, $p<0.001$), Cognitive-behaviour ($t(17) = 3.262$, $p<0.005$), Cognitive ($t(17) = 3.808$, $p<0.001$) and Conversational ($t(17) = 2.848$, $p<0.05$) therapy groups.

1.1.2 Late Sessions

A series of one-way ANOVAs showed an overall effect of type of therapy in late sessions of the six therapy groups of the percentage of patient statements containing explicit references to the therapist ($F(5, 17) = 8.449$, $p<0.001$), parents ($F(5, 17) = 14.886 = p<0.001$) and conflict ($F(5, 17) = 7.823$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Behaviour ($t(17) = 4.953$, $p<0.001$), Cognitive-behaviour ($t(17) = 4.885$, $p<0.001$), Cognitive ($t(17) = 4.691$, $p<0.001$) and Conversational ($t(17) = 2.778$, $p<0.05$) therapy groups; to parents than the Behaviour ($t(17) = 2.783$, $p<0.05$), Cognitive-behaviour ($t(17) = 2.853$, $p<0.05$), Cognitive ($t(17) = 2.777$, $p<0.05$) and Conversational ($t(17) = 2.145$, $p<0.05$) therapy groups; and to conflict than the Behaviour ($t(17) = 3.634$, $p<0.05$), Cognitive-behaviour ($t(17) = 2.671$, $p<0.05$) and Cognitive ($t(17) = 3.275$, $p<0.005$) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Behaviour ($t(17) = 3.298$, $p<0.005$), Cognitive-behaviour ($t(17) = 2.994$, $p<0.01$) and Cognitive ($t(17) = 2.939$, $p<0.01$) therapy groups; to parents than the Behaviour ($t(17) = 7.122$, $p<0.001$), Cognitive-behaviour ($t(17) = 7.518$, $p<0.001$), Cognitive ($t(17) = 7.320$,

$p<0.001$) and Conversational ($t(17) = 6.950$, $p<0.001$) therapy groups; and conflict than the Behaviour ($t(17) = 4.926$, $p<0.001$), Cognitive-behaviour ($t(17) = 4.199$, $p<0.001$), Cognitive ($t(17) = 4.661$, $p<0.001$) and Conversational ($t(17) = 2.687$, $p<0.05$) therapy groups.

1.2 Mean

1.2.1 Early Sessions

A series of one-way ANOVAs showed an overall effect of type of therapy in early sessions of the six therapy groups of the mean number of explicit references in patient statements to the therapist ($F(5, 17) = 12.327$, $p<0.001$), parents ($F(5, 17) = 4.151$, $p<0.05$) and conflict ($F(5, 17) = 4.503$, $p<0.01$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher mean number of explicit references in patient statements to the therapist than the Behaviour ($t(17) = 2.408$, $p<0.05$) and Cognitive-behaviour ($t(17) = 2.433$, $p<0.05$) therapy groups; and to parents than the Cognitive-behaviour ($t(17) = 2.504$, $p<0.05$) and Cognitive ($t(17) = 2.459$, $p<0.05$) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher mean number of explicit references in patient statements to the therapist than the Behaviour ($t(17) = 6.676$, $p<0.001$), Cognitive-behaviour ($t(17) = 7.036$, $p<0.001$), Cognitive ($t(17) = 6.623$, $p<0.001$) and Conversational ($t(17) = 5.732$, $p<0.001$) therapy groups; to parents than the Behaviour ($t(17) = 3.062$, $p<0.01$), Cognitive-behaviour ($t(17) = 3.598$, $p<0.005$), Cognitive ($t(17) = 3.544$, $p<0.005$) and Conversational ($t(17) = 3.264$, $p<0.005$) therapy groups; and conflict than the Behaviour ($t(17) = 4.015$, $p<0.001$), Cognitive-behaviour ($t(17) = 3.685$, $p<0.005$), Cognitive ($t(17) = 4.158$, $p<0.001$) and Conversational ($t(17) = 3.505$, $p<0.005$) therapy groups.

1.2.2 Late Sessions

A series of one-way ANOVAs showed an overall effect of type of therapy in late sessions of the six therapy groups of the mean number of explicit references in patient statements to parents ($F(5, 17) = 4.459 = p<0.01$) and conflict ($F(5, 17) = 5.692$, $p<0.005$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher mean number of patient explicit references in statements to conflict than the Behaviour ($t(17) = 3.395$, $p<0.005$), Cognitive-behaviour ($t(17) = 2.887$, $p<0.01$) and Cognitive ($t(17) = 3.265$, $p<0.005$) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher mean number of patient explicit references in statements to parents than the Behaviour ($t(17) = 3.922$, $p<0.001$), Cognitive-behaviour ($t(17) = 4.187$, $p<0.001$), Cognitive ($t(17) = 4.094$, $p<0.001$) and Conversational ($t(17) = 4.124$, $p<0.001$) therapy groups; and conflict than the Behaviour ($t(17) = 3.875$, $p<0.001$), Cognitive-behaviour ($t(17) = 3.444$, $p<0.005$), Cognitive ($t(17) = 3.757$, $p<0.005$) and Conversational ($t(17) = 2.300$, $p<0.05$) therapy groups.

1.3 Rate

1.3.1 Early Sessions

A series of one-way ANOVAs showed an overall effect of type of therapy in early sessions of the six therapy groups of the rate of patient explicit references to the therapist ($F(5, 17) = 6.345$, $p<0.005$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher rate of references to the therapist than the Behaviour ($t(17) = 2.528$, $p<0.05$) and Cognitive-behaviour ($t(17) = 2.470$, $p<0.05$) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher rate of references to the therapist than the Behaviour ($t(17) = 4.823$, $p<0.001$), Cognitive-behaviour (t

(17) = 4.935, p<0.001), Cognitive (t (17) = 4.074, p<0.001) and Conversational (t (17) = 3.718, p<0.005) therapy groups.

1.3.2 Late Sessions

A series of one-way ANOVAs showed an overall effect of type of therapy in late sessions of the six therapy groups of the rate of patient explicit references to parents (F (5, 17) = 4.076 = p<0.05). A priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher rate of references to parents than the Behaviour (t (17) = 3.808, p<0.001), Cognitive-behaviour (t (17) = 3.812, p<0.001), Cognitive (t (17) = 3.918, p<0.001) and Conversational (t (17) = 3.863, p<0.001) therapy groups.

2. Therapist Explicit References

2.1 Percentage

2.1.1 Early Sessions

A one-way ANOVA showed an overall effect of type of therapy in early sessions of the six therapy groups of the percentage of therapist statements containing explicit references to the therapist (F (5, 17) = 5.784, p<0.005). A priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Cognitive-behaviour (t (17) = 4.685, p<0.001) and Cognitive (t (17) = 4.085, p<0.001) therapy groups.

2.1.2 Late Sessions

A one-way ANOVA also showed an overall effect of type of therapy in late sessions of the six therapy groups of the percentage of therapist statements containing explicit references to the therapist (F (5, 17) = 10.474, p<0.001). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Behaviour (t (17) = 5.197, p<0.001), Cognitive-behaviour (t (17) = 5.697, p<0.001) and Cognitive (t (17) = 5.093, p<0.001) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Behaviour (t (17) = 3.556, p<0.005), Cognitive-behaviour (t (17) = 3.704, p<0.005) and Cognitive (t (17) = 3.324, p<0.005) therapy groups.

2.2 Mean

2.2.1 Early Sessions

A one-way ANOVA showed an overall effect of type of therapy in early sessions of the six therapy groups on the mean number of explicit references to themselves in therapists' statements (F (5, 17) = 5.549, p<0.005). A priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher percentage of statements containing references to the therapist than the Cognitive-behaviour (t (17) = 4.865, p<0.001) and Cognitive (t (17) = 4.131, p<0.001) therapy groups.

2.2.2 Late Sessions

A one-way ANOVA showed an overall effect of type of therapy in late sessions of the six therapy groups of the mean number of explicit references to themselves in therapists' statements (F (5, 17) = 12.298, p<0.001). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher mean number of references to the therapist than the Behaviour (t (17) = 5.709, p<0.001), Cognitive-behaviour (t (17) = 6.281, p<0.001) and Cognitive (t (17) = 5.656, p<0.001) therapy groups. A further series of a priori contrasts

showed the Psychoanalytic psychotherapy group to contain a higher mean number of references to the therapist than the Behaviour ($t(17) = 3.516$, $p<0.005$), Cognitive-behaviour ($t(17) = 3.661$, $p<0.005$) and Cognitive ($t(17) = 3.289$, $p<0.005$) therapy groups.

A further series of one-way ANOVAs showed an overall effect of type of therapy in late sessions of the six therapy groups of the mean number of different transference components per therapist statement referred to explicitly ($F(5, 17) = 29.912$, $p<0.001$), implicitly ($F(5, 17) = 5.018$, $p<0.005$) and explicitly and implicitly combined ($F(5, 17) = 19.145$, $p<0.001$). However a priori contrasts did not show any significant differences across groups though they did show the three Cognitive-behaviour therapy groups to contain higher mean numbers of different components implicitly referred to than the Psychoanalytic group but these were not significant.

2.3 Rate

2.3.1 Early Sessions

A one-way ANOVA showed an overall effect of type of therapy in early sessions of the six therapy groups on the rate of therapists' explicit references to themselves ($F(5, 17) = 5.072$, $p<0.005$). A priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher rate than the Cognitive-behaviour ($t(17) = 3.972$, $p<0.001$) and Cognitive ($t(17) = 4.276$, $p<0.001$) therapy groups.

2.3.2 Late Sessions

A one-way ANOVA showed an overall effect of type of therapy in late sessions of the six therapy groups of the rate of explicit references to themselves by therapists ($F(5, 17) = 11.881$, $p<0.001$). A priori contrasts showed the Psychodynamic psychotherapy group to contain a higher mean number of references to the therapist than the Behaviour ($t(17) = 4.913$, $p<0.001$), Cognitive-behaviour ($t(17) = 5.892$, $p<0.001$) and Cognitive ($t(17) = 4.635$, $p<0.001$) therapy groups. A further series of a priori contrasts showed the Psychoanalytic psychotherapy group to contain a higher mean number of references to the therapist than the Behaviour ($t(17) = 3.873$, $p<0.005$), Cognitive-behaviour ($t(17) = 3.462$, $p<0.005$) and Cognitive ($t(17) = 3.563$, $p<0.005$) therapy groups.

A further series of one-way ANOVAs showed an overall effect of type of therapy in late sessions of the six therapy groups of the rate of different transference components referred to explicitly ($F(5, 17) = 20.316$, $p<0.001$), implicitly ($F(5, 17) = 11.394$, $p<0.001$) and explicitly and implicitly combined ($F(5, 17) = 21.393$, $p<0.001$). However the only significant differences a priori contrasts showed was of the Behaviour, Cognitive-behaviour and Cognitive therapy groups containing a higher mean number of different components implicitly referred to than the Psychoanalytic group ($t(17) = 5.932$, $p<0.001$; $t(17) = 5.156$, $p<0.001$ and $t(17) = 4.800$, $p<0.001$ respectively).

APPENDIX IX

RESULTS II

Coding System of Therapeutic Focus (Percentage and Mean Data)

1. Comparison of Coding Categories across Types of Therapy

1.1 Components of Patient Functioning

The percentage of statements within sessions in which each category of components of patient functioning was focused on by therapists was analysed. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.1. Percentages are also presented for each of the six therapy groups in Table A.2.

The mean number of times per therapist statement each category of components of patient functioning was focused on by therapists across the two therapy groupings is presented in Table A.3 and across the six therapy groups is presented in Table A.4.

Table A.1. Percentage of therapist statements containing each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Situation	13.92 (9.46)	3.63 (5.91)
Self Observation	6.53 (5.77)	16.01 (19.38)
Self Evaluation	5.13 (5.13)	7.11 (8.09)
Expectations	2.13 (1.38)	7.11 (6.97)
General Thoughts	14.78 (11.10)	25.36 (19.89)
Intentions	3.07 (2.64)	2.19 (4.20)
Emotions	15.73 (7.55)	47.76 (20.95)
Actions	19.81 (7.56)	17.33 (18.35)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements focusing on each component of patient functioning and the mean number of times each component was focused on within therapist statements. These tests showed Psychodynamic psychotherapies to contain a significantly higher percentage of therapist statements than Cognitive-behaviour therapies referring to emotions and a higher

mean of these references (t (22) = 4.981, p<0.001 and t (22) = 5.005, p<0.001 respectively). The tests also showed Cognitive-behaviour therapies to contain a significantly higher percentage of therapist statements than did Psychodynamic referring to situations and a higher mean of these references (t (18.436) = 3.194, p<0.005 and t (18.642) = 3.198, p<0.005 respectively).

Table A.2. Percentage of therapist statements containing each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Situation	11.30	18.50	11.95	2.45	5.65	2.78
	(14.03)	(8.94)	(3.14)	(4.90)	(8.05)	(5.55)
Self Observation	4.00	5.05	10.55	4.53	5.10	38.40
	(3.81)	(4.17)	(7.56)	(1.76)	(1.87)	(19.17)
Self Evaluation	0.45	5.60	9.32	4.28	5.25	11.80
	(0.57)	(1.04)	(6.48)	(1.32)	(2.59)	(13.67)
Expectations	0.90	2.48	3.03	6.68	5.60	9.03
	(0.73)	(1.27)	(1.24)	(1.34)	(5.23)	(11.87)
General Thoughts	10.43	17.75	16.18	16.28	42.83	16.98
	(13.31)	(12.98)	(8.17)	(6.18)	(19.08)	(20.92)
Intentions	1.70	3.10	4.40	3.00	0.00	3.58
	(2.40)	(1.74)	(3.45)	(1.93)	(0.00)	7.15
Emotions	11.50	21.25	14.45	45.58	32.10	65.60
	(4.55)	(7.49)	(8.11)	(17.95)	(16.69)	(15.85)
Actions	18.98	21.68	18.78	13.60	3.58	34.83
	(9.00)	(9.94)	(4.77)	(3.54)	(5.55)	(22.63)

Table A.3. Mean total of each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus contained in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Situation	0.139 (0.094)	0.036 (0.060)
Self Observation	0.064 (0.057)	0.160 (0.195)
Self Evaluation	0.054 (0.057)	0.068 (0.081)
Expectations	0.022 (0.014)	0.071 (0.069)
General Thoughts	0.150 (0.111)	0.261 (0.216)
Intentions	0.031 (0.026)	0.022 (0.041)
Emotions	0.165 (0.083)	0.498 (0.215)
Actions	0.206 (0.081)	0.176 (0.183)

Table A.4. Mean total of each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus contained in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Situation	0.112	0.185	0.121	0.024	0.058	0.028
	(0.139)	(0.088)	(0.031)	(0.049)	(0.083)	(0.055)
Self Observation	0.035	0.051	0.108	0.045	0.051	0.385
	(0.031)	(0.042)	(0.072)	(0.018)	(0.019)	(0.193)
Self Evaluation	0.004	0.056	0.100	0.043	0.045	0.118
	(0.006)	(0.010)	(0.076)	(0.013)	(0.014)	(0.136)
Expectations	0.009	0.025	0.034	0.067	0.055	0.090
	(0.007)	(0.013)	(0.011)	(0.014)	(0.051)	(0.119)
General Thoughts	0.104	0.176	0.170	0.163	0.450	0.170
	(0.132)	(0.129)	(0.084)	(0.060)	(0.229)	(0.210)
Intentions	0.017	0.031	0.045	0.030	0.000	0.035
	(0.024)	(0.018)	(0.034)	(0.019)	(0.000)	(0.070)
Emotions	0.116	0.218	0.161	0.490	0.345	0.658
	(0.047)	(0.073)	(0.103)	(0.212)	(0.184)	(0.159)
Actions	0.195	0.228	0.195	0.138	0.044	0.348
	(0.097)	(0.110)	(0.042)	(0.039)	(0.072)	(0.229)

The Six Therapy Groups

One-way ANOVAs for the percentage of therapist statements focusing on self observation and the mean of these showed an overall significant effect of type of therapy ($F(5, 18) = 9.448$, $p<0.001$ and $F(5, 18) = 9.706$, $p<0.001$ respectively). Further analyses showed higher percentages and higher means of such references in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe tests, $p<0.005$ and $p<0.001$ respectively), Cognitive-behaviour (Scheffe tests, $p<0.005$ and $p<0.005$ respectively), Conversational (Scheffe tests, $p<0.005$ and $p<0.005$ respectively) and Psychodynamic (Scheffe test, $p<0.005$ and $p<0.005$ respectively) therapy groups.

One-way ANOVAs for the percentage of therapist statements focusing on thoughts did not show a significant difference between the six therapy groups ($F(5, 18) = 2.512$, $p<0.068$). An a priori contrast, however, did show the Psychodynamic group to contain a higher percentage of statements containing such references than did the Psychoanalytic group ($t(18) = 2.531$, $p<0.05$).

A one-way ANOVA for the mean coding of thoughts showed an overall significant effect of type of therapy ($F(5, 18) = 5.097$, $p<0.001$) with an a priori contrast showing the Psychodynamic group to have a higher mean coding than the Psychoanalytic group ($t(18) = 2.647$, $p<0.05$).

One-way ANOVAs for the percentage of therapist statements focusing on emotions and the mean coding of these showed an overall significant effect of type of therapy ($F(5, 18) = 10.411$, $p<0.001$ and $F(5, 18) = 8.638$, $p<0.001$). A priori contrasts showed higher percentages and higher means of these references in the Psychoanalytic psychotherapy group than in the Behaviour ($t(18) = 5.943$, $p<0.001$ and $t(18) = 5.568$, $p<0.001$ respectively), Cognitive-behaviour ($t(18) = 4.872$, $p<0.001$ and $t(18) = 6.635$, $p<0.001$ respectively),

Cognitive (t (18) = 5.619, p<0.001 and t(18) = 6.167, p<0.001 respectively), Conversational (t (18) = 2.200, p<0.05 and t (18) = 4.248, p<0.001 respectively) and Psychodynamic (t (18) = 3.680, p<0.005 and t (18) = 4.468, p<0.001 respectively) therapy groups. A further series of a priori contrasts showed higher percentages and higher means of references to emotions in the Psychodynamic psychotherapy group than in the Behaviour therapy group (t (18) = 2.263, p<0.05 and t (18) = 2.149, p<0.05 respectively).

A one-way ANOVA for the percentage of therapist statements focusing on actions and for the mean occurrence of focus on actions also showed an overall significant effect of type of therapy (F (5, 18) = 3.315, p<0.05 and F (5, 18) = 2.939, p<0.05 respectively).

No other analyses of components of patient functioning showed any significant differences either across the two therapy groupings or the six therapy groups.

1.2 General Interventions

The percentage of statements within sessions in which each category of general interventions was focused on by therapists was analysed. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.5. Percentages are also presented for each of the six therapy groups in Table A.6.

The mean number of times per therapist statement each category of general interventions was focused on by therapists across the two therapy groupings is presented in Table A.7 and across the six therapy groups is presented in Table A.8.

Table A.5. Percentage of therapist statements containing each coding category of General Interventions of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category				
Reality/Unreality	9.56	(9.94)	12.02	(10.30)
Expected/Imagined Reaction	4.88	(5.68)	13.77	(20.49)
Inst./Sig.Theme	1.36	(1.91)	2.70	(2.93)
Therapist Support	2.25	(1.99)	0.14	(0.49)
Information Giving	1.03	(0.99)	0.00	(0.00)
Changes	2.02	(1.47)	0.89	(2.24)
Avoidance	0.68	(1.52)	12.68	(18.11)
Self Disclosure	1.56	(2.03)	0.30	(0.70)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements containing general interventions and the mean number of times general interventions were focused on within therapist statements. These tests showed Cognitive-behaviour therapies to contain significantly higher percentage and mean scores of

therapist giving of support (t (22) = 3.588, p<0.005 and t (22) = 3.555, p<0.005 respectively) and information (t (22) = 3.588, p<0.005 and t (22) = 3.553, p<0.005 respectively) than did Psychodynamic psychotherapies. The tests also showed Psychodynamic psychotherapies to contain significantly higher percentage and mean scores than did Cognitive-behaviour referring to avoidance (t (22) = 2.288, p<0.05 and t (22) = 2.277, p<0.05 respectively).

The Cognitive-behaviour therapy grouping showed a higher mean total of references to self disclosure than the Psychodynamic grouping of psychotherapies and this approached significance (t (13.465) = 2.011, p<0.57).

Table A.6. Percentage of therapist statements containing each coding category of General Interventions of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Reality/Unreality	1.08	9.03	18.58	9.28	3.08	23.70
	(1.77)	(5.20)	(11.29)	(4.78)	(2.41)	(7.84)
Exp./Imag.Reaction	1.25	4.18	9.20	4.10	15.68	21.53
	(1.03)	(3.98)	(7.64)	(4.14)	(3.81)	(36.03)
Inst./Sig.Theme	0.00	2.58	1.50	4.40	3.73	0.00
	(0.00)	(2.56)	(1.52)	(2.34)	(3.32)	(0.00)
Therapist Support	2.50	1.70	2.55	0.43	0.00	0.00
	(1.26)	(2.61)	(2.36)	(0.85)	(0.00)	(0.00)
Information Giving	1.28	0.90	0.93	0.00	0.00	0.00
	(1.39)	(1.15)	(0.53)	(0.00)	(0.00)	(0.00)
Changes	1.38	2.03	2.65	0.85	1.83	0.00
	(1.63)	(1.86)	(0.82)	(1.70)	(3.65)	(0.00)
Avoidance	0.00	1.28	0.75	7.75	4.50	25.80
	(0.00)	(2.55)	(0.93)	(2.40)	(4.29)	(28.77)
Self Disclosure	3.05	0.98	0.65	0.90	0.00	0.00
	(3.14)	(0.68)	(0.51)	(1.04)	(0.00)	(0.00)

Table A.7. Mean total of each coding category of General Interventions of the Coding System of Therapeutic Focus contained in therapist statements (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Reality/Unreality	0.095 (0.099)	0.120 (0.102)
Exp./Imag.Reaction	0.050 (0.060)	0.138 (0.205)
Inst./Sig.Theme	0.013 (0.019)	0.027 (0.029)
Therapist Support	0.023 (0.020)	0.001 (0.005)
Information Giving	0.010 (0.010)	0.000 (0.000)
Changes	0.020 (0.015)	0.009 (0.022)
Avoidance	0.007 (0.015)	0.127 (0.182)
Self Disclosure	0.015 (0.020)	0.003 (0.007)

Table A.8. Mean total of each coding category of General Interventions of the Coding System of Therapeutic Focus contained in therapist statements (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Reality/Unreality	0.010	0.090	0.185	0.092	0.033	0.235
	(0.018)	(0.052)	(0.111)	(0.047)	(0.026)	(0.079)
Exp./Imag.Reaction	0.013	0.042	0.096	0.041	0.160	0.215
	(0.010)	(0.040)	(0.082)	(0.041)	(0.038)	(0.360)
Inst./Sig.Theme	0.000	0.026	0.015	0.044	0.037	0.000
	(0.000)	(0.026)	(0.015)	(0.023)	(0.033)	(0.000)
Therapist Support	0.025	0.017	0.026	0.004	0.000	0.000
	(0.013)	(0.026)	(0.024)	(0.008)	(0.000)	(0.000)
Information Giving	0.013	0.009	0.009	0.000	0.000	0.000
	(0.014)	(0.011)	(0.006)	(0.000)	(0.000)	(0.000)
Changes	0.014	0.020	0.027	0.008	0.018	0.000
	(0.016)	(0.019)	(0.008)	(0.017)	(0.087)	(0.000)
Avoidance	0.000	0.012	0.008	0.078	0.045	0.258
	(0.000)	(0.026)	(0.009)	(0.025)	(0.043)	(0.290)
Self Disclosure	0.031	0.010	0.006	0.009	0.000	0.000
	(0.032)	(0.007)	(0.005)	(0.010)	(0.000)	(0.000)

The Six Therapy Groups

One-way ANOVAs for the percentage of therapist statements focusing on reality-unreality and for the mean of these showed overall significant effects of type of therapy ($F(5, 18) = 7.491$, $p<0.001$ and $F(5, 18) = 7.452$, $p<0.001$ respectively). Further analyses showed higher percentages and higher means of focus on reality-unreality in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe tests, $p<0.005$ and $p<0.005$ respectively).

No other analyses of general interventions showed any significant differences either across the two therapy groupings or the six therapy groups.

1.3 Intrapersonal Links

The percentage of statements within sessions in which each category of intrapersonal links was focused on by therapists was analysed. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.9. Percentages are also presented for each of the six therapy groups in Table A.10.

The mean number of times per therapist statement each category of intrapersonal links was focused on by therapists across the two therapy groupings is presented in Table A.11 and across the six therapy groups is presented in Table A.12.

Table A.9. Percentage of therapist statements containing each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category				
Similarity/Patterns	3.21	(3.10)	6.52	(8.71)
Difference/Incongruity	1.70	(2.20)	3.75	(4.54)
Vicious Circle	0.16	(0.38)	0.20	(0.69)
Consequences	5.46	(5.04)	21.78	(19.32)

Table A.10. Percentage of therapist statements containing each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Coding Category					
Similarity/Patterns	0.88	5.98	2.78	2.03	5.73	11.80
	(0.84)	(3.53)	(2.09)	(1.58)	(4.85)	(13.67)
Difference/Incongruity	0.20	3.35	1.55	2.70	4.98	3.58
	(0.24)	(3.24)	(0.74)	(1.81)	(4.21)	(7.15)
Vicious Cycle	0.00	0.20	0.28	0.60	0.00	0.00
	(0.00)	(0.40)	(0.55)	(1.20)	(0.00)	(0.00)
Consequences	1.30	10.03	5.05	14.05	10.20	41.08
	(1.68)	(5.78)	(2.36)	(10.09)	(2.77)	(22.46)

Table A.11. Mean total of each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category				
Similarity/Patterns	0.032	(0.032)	0.065	(0.087)
Difference/Incongruity	0.017	(0.022)	0.037	(0.044)
Vicious Circle	0.002	(0.004)	0.002	(0.007)
Consequences	0.057	(0.053)	0.218	(0.194)

Table A.12. Mean total of each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category						
Similarity/Patterns	0.009	0.061	0.028	0.020	0.058	0.118
	(0.009)	(0.037)	(0.021)	(0.016)	(0.049)	(0.136)
Difference/Incongruity	0.002	0.034	0.016	0.027	0.049	0.035
	(0.002)	(0.032)	(0.007)	(0.018)	(0.041)	(0.070)
Vicious Cycle	0.000	0.002	0.003	0.006	0.000	0.000
	(0.000)	(0.004)	(0.005)	(0.012)	(0.000)	(0.000)
Consequences	0.013	0.103	0.056	0.142	0.102	0.410
	(0.017)	(0.060)	(0.030)	(0.103)	(0.028)	(0.227)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements containing intrapersonal links and the mean number of times intrapersonal links were focused on within therapist statements. These tests showed Psychodynamic psychotherapies to contain significantly higher percentage and mean scores of therapist focus on intrapersonal consequences than did Cognitive-behaviour therapies ($t(22) = 2.831$, $p<0.01$ and $t(22) = 2.274$, $p<0.01$).

The Six Therapy Groups

One-way ANOVAs for the percentage of therapist statements focusing on intrapersonal consequences and the mean of these references showed overall significant effects of type of therapy ($F(5, 18) = 7.346$, $p<0.001$ and $F(5, 18) = 6.995$, $p<0.001$ respectively). Further analyses showed higher percentage and higher mean scores in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe tests, $p<0.005$ and $p<0.005$ respectively) and Cognitive (Scheffe tests, $p<0.01$ and $p<0.01$ respectively).

No other analyses of intrapersonal links showed any significant differences either across the two therapy groupings or the six therapy groups.

1.4 Interpersonal Links

The percentage of statements within sessions in which each category of interpersonal links was focused on by therapists was analysed. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.13. Percentages are also presented for each of the six therapy groups in Table A.14.

The mean number of times per therapist statement each category of intrapersonal links was focused on by therapists across the two therapy groupings is presented in Table A.15 and across the six therapy groups is presented in Table A.16.

Table A.13. Percentage of therapist statements containing each coding category of Interpersonal Links of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category				
Patterns	1.55	(2.25)	5.08	(5.20)
Vicious Cycle	0.04	(0.14)	0.86	(2.97)
Consequences	2.04	(1.93)	5.90	(6.44)
Direction of consequences:				
patient to other	0.13	(0.34)	2.00	(3.34)
other to patient	1.91	(1.99)	3.90	(3.97)
Compares/Contrasts	1.63	(1.68)	0.74	(1.15)
General Interaction	2.21	(2.19)	3.77	(4.84)

Table A.14. Percentage of therapist statements containing each coding category of Interpersonal Links of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category						
Patterns	0.15	3.08	1.43	3.90	4.98	6.35
	(0.30)	(3.14)	(1.69)	(4.21)	(4.68)	(7.45)
Vicious Cycle	0.00	0.00	0.13	0.00	2.58	0.00
	(0.00)	(0.00)	(0.25)	(0.00)	(5.15)	(0.00)
Consequences	1.43	3.58	1.13	5.43	6.73	5.55
	(1.49)	(2.36)	(1.08)	(2.39)	(4.65)	(11.10)
Dir. of Conseq.:						
patient to other	0.00	0.28	0.13	1.35	1.88	2.78
	(0.00)	(0.55)	(0.25)	(1.76)	(2.36)	(5.55)
other to patient	1.43	3.30	1.00	4.08	4.85	2.78
	(1.49)	(2.62)	(1.20)	(2.22)	(4.38)	(5.55)
Compares/Contrasts	0.70	2.25	1.93	0.98	1.25	0.00
	(0.55)	(2.64)	(1.11)	(1.28)	(1.45)	(0.00)
General Interaction	1.98	3.65	1.00	10.13	1.17	0.00
	(2.88)	(1.94)	(0.90)	(1.52)	(1.36)	(0.00)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements containing interpersonal links and the mean number of times interpersonal links were focused on within therapist statements. These tests showed Psychodynamic psychotherapies to contain significantly higher percentage and mean scores of therapist focus on interpersonal patterns ($t(22) = 2.156$, $p<0.05$ and $t(22) = 2.277$, $p<0.05$ respectively), significantly higher percentage scores of focus on the patient's impact on others

(t (22) = 1.927, $p<0.05$) and significantly higher mean scores of focus on consequences (t (22) = 2.356, $p<0.05$). Both groups contained lower percentage and mean scores of focus on patients' impact on others than of focus on the impact of others on the patient.

Table A.15. Mean total of each coding category of Interpersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patterns	0.013 (0.023)	0.050 (0.051)
Vicious Cycle	0.000 (0.000)	0.008 (0.029)
Consequences	0.020 (0.019)	0.059 (0.064)
Direction of consequences:		
patient to other	0.001 (0.003)	0.023 (0.033)
other to patient	0.019 (0.020)	0.036 (0.040)
Compares/Contrasts	0.016 (0.017)	0.010 (0.017)
General Interaction	0.022 (0.022)	0.038 (0.049)

Table A.16. Mean total of each coding category of Interpersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category						
Patterns	0.001 (0.003)	0.031 (0.031)	0.008 (0.016)	0.039 (0.042)	0.049 (0.046)	0.063 (0.073)
Vicious Cycle	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.025 (0.050)	0.000 (0.000)
Consequences	0.014 (0.015)	0.035 (0.023)	0.011 (0.011)	0.054 (0.024)	0.067 (0.046)	0.055 (0.110)
Dir. of Conseq.:						
patient to other	0.000 (0.000)	0.003 (0.006)	0.001 (0.002)	0.013 (0.018)	0.018 (0.023)	0.028 (0.055)
other to patient	0.014 (0.015)	0.032 (0.026)	0.010 (0.012)	0.041 (0.023)	0.048 (0.043)	0.028 (0.055)
Compares/Contrasts	0.007 (0.006)	0.023 (0.027)	0.019 (0.011)	0.010 (0.013)	0.019 (0.024)	0.000 (0.000)
General Interaction	0.020 (0.029)	0.036 (0.020)	0.010 (0.009)	10.13 (1.52)	0.012 (0.014)	0.000 (0.000)

The Six Therapy Groups

One-way ANOVAs for the percentage of therapist statements focusing on general interactions and for the mean of these references showed overall significant effects of type of therapy (F

(5, 18) = 19.356, p<0.001and F (5, 18) = 19.182, p<0.001 respectively). Further analyses showed higher percentage and mean scores of focus on general interaction in the Conversational psychotherapy group than in the Behaviour (Scheffe tests, p<0.001 and p<0.001 respectively), Cognitive-behaviour (Scheffe tests, p<0.005 and p<0.005 respectively), Cognitive (Scheffe tests, p<0.001 and p<0.001 respectively), Psychodynamic (Scheffe tests, p<0.001 and p<0.001 respectively) and Psychoanalytic (Scheffe tests, p<0.001 and p<0.001 respectively) therapy groups.

No other analyses of intrapersonal links showed any significant differences either across the two therapy groupings or the six therapy groups.

1.5 The Total of Interpersonal and Intrapersonal References and the Ratio of Interpersonal to Intrapersonal References

The total percentage of statements within sessions in which intrapersonal links and in which interpersonal links were focused on by therapists was analysed. The total percentages of these intrapersonal and interpersonal links divided by the respective numbers of different coding categories subsumed within each was also calculated. So too was the ratio of intrapersonal to interpersonal references in groups. These mean percentages and ratios are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.17. Percentages are also presented for each of the six therapy groups in Table A.18.

The mean total number of intrapersonal and interpersonal links focused on per therapist statement across the two therapy groupings is presented in Table A.19 and across the six therapy groups is presented in Table A.20.

Table A.17. Mean Total Percentage of therapist statements containing Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus and the Ratio of these factors within groups (standard deviation in brackets)

Group Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Intrapersonal Total	10.53 (9.76)	32.24 (22.60)
Intrapersonal Total/ no of Factors	2.63 (2.44)	8.06 (5.65)
Interpersonal Total	7.47 (4.86)	16.34 (11.87)
Interpersonal Total/ no of Factors	1.49 (0.97)	3.27 (2.37)
Ratio of Intrapersonal to Interpersonal Factors	1.41 : 1	1.97 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	1.77 : 1	2.46 : 1

Table A.18. Mean Total Percentage of therapist statements containing Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus and the Ratio of these factors within groups (standard deviation in brackets)

Group	Behaviour		Cognitive		Psychodynamic	
Coding Category		Cog.-beh.		Conversational		Psychoanalytic
Intrapersonal Total	2.38	19.55	9.65	19.38	20.90	56.45
	(2.12)	(10.81)	(5.45)	(13.06)	(10.93)	(20.21)
Intrapersonal Total/ no of Factors	0.59	4.89	2.41	4.84	5.23	14.11
	(0.53)	(2.70)	(1.36)	(3.26)	(2.73)	(5.05)
Interpersonal Total	4.25	12.55	5.60	20.43	16.70	11.90
	(3.70)	(3.78)	(2.41)	(5.14)	(13.86)	(15.78)
Interpersonal Total/ no of Factors	0.85	2.51	1.12	4.09	3.34	2.38
	(0.74)	(0.76)	(0.48)	(1.09)	(2.77)	(3.16)
Ratio of Intrapersonal to Interpersonal Factors	0.56: 1	1.56 : 1	1.72 : 1	0.95 : 1	1.25 : 1	4.74 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	0.69 : 1	1.99 : 1	2.15 : 1	1.18 : 1	1.57 : 1	5.92 : 1

Table A.19. Mean Total of Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus in therapist statements and the Ratio of these factors within groups (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Intrapersonal Total	0.108 (0.100)	0.322 (0.226)
Intrapersonal Total/ no of Factors	0.027 (0.025)	0.081 (0.057)
Interpersonal Total	0.072 (0.049)	0.165 (0.121)
Interpersonal Total/ no of Factors	0.014 (0.010)	0.033 (0.024)
Ratio of Intrapersonal to Interpersonal Factors	1.50 : 1	1.95 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	1.93 : 1	2.45 : 1

Table A.20. Mean Total of Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus in therapist statements and the Ratio of these factors within groups (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
Coding Category		Cog.-beh.		Conversational		Psychoanalytic
Intrapersonal Total	0.024	0.199	0.102	0.196	0.209	0.563
	(0.021)	(0.112)	(0.059)	(0.133)	(0.110)	(0.205)
Intrapersonal Total/ no of Factors	0.006	0.050	0.026	0.049	0.052	0.141
	(0.005)	(0.028)	(0.015)	(0.033)	(0.027)	(0.051)
Interpersonal Total	0.043	0.125	0.049	0.205	0.172	0.118
	(0.037)	(0.037)	(0.023)	(0.051)	(0.145)	(0.156)
Interpersonal Total/ no of Factors	0.009	0.025	0.010	0.041	0.034	0.024
	(0.007)	(0.007)	(0.005)	(0.010)	(0.029)	(0.031)
Ratio of Intrapersonal to Interpersonal Factors	0.56 : 1	1.59 : 1	2.08 : 1	0.96 : 1	1.22 : 1	4.77 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	0.67 : 1	2.00 : 1	2.60 : 1	1.20 : 1	1.53 : 1	5.88 : 1

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the total percentages of therapists' statements containing intrapersonal and interpersonal factors across the two groupings of therapies, Psychodynamic and Cognitive-behaviour, and their mean totals. The tests also compared the total percentages and the mean totals of intrapersonal factors divided by the number of intrapersonal coding categories (4) and the mean total percentages of interpersonal factors divided by the number of interpersonal coding categories (5). These tests showed Psychodynamic psychotherapies to contain a significantly higher percentage and mean scores than Cognitive-behaviour therapies on all four variables: intrapersonal total ($t(22) = 3.056$, $p<0.01$ and $t(22) = 2.996$, $p<0.01$ respectively), intrapersonal total divided by number of factors ($t(22) = 3.056$, $p<0.01$and $t(22) = 2.996$, $p<0.01$ respectively), interpersonal total ($t(22) = 2.398$, $p<0.05$ and $t(22) = 2.455$, $p<0.05$ respectively) and interpersonal total divided by number of factors ($t(22) = 2.398$, $p<0.05$ and $t(22) = 2.455$, $p<0.05$ respectively). Both groups contained higher total percentage scores and higher total mean scores of references to intrapersonal factors than to interpersonal factors.

The Six Therapy Groups

One-way ANOVAs for the total percentage of therapist statements in which intrapersonal factors were coded and for the total mean for these references showed overall significant effects of type of therapy ($F(5, 18) = 9.810$, $p<0.001$ and $F(5, 18) = 9.281$, $p<0.001$). Further analyses showed higher percentage and mean scores in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe tests, $p<0.001$ and $p<0.001$ respectively) and Cognitive therapy groups (Scheffe tests, $p<0.005$ and $p<0.005$ respectively).

No other analyses of summated intrapersonal and summated interpersonal links showed any significant differences either across the two therapy groupings or the six therapy groups.

1.6 Who Therapists Focus On

The percentage of statements within sessions in which the various person categories were coded was analysed. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.21. Percentages are also presented for each of the six therapy groups in Table A.22.

The mean number of times per therapist statement each person category was focused on by therapists across the two therapy groupings is presented in Table A.23 and across the six therapy groups is presented in Table A.24.

Table A.21. Percentage of therapist statements containing each coding category of Persons Involved of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patient	75.68 (16.24)	75.21 (26.17)
Therapist	7.82 (4.26)	14.84 (10.90)
Parent	1.35 (1.79)	21.21 (15.65)
Mate	5.35 (8.25)	10.63 (17.18)
Child	2.45 (4.18)	4.04 (7.71)
Dream/Fantasy Figure	0.00 (0.00)	1.04 (2.16)
Acquaintance/Strangers and Others in General	15.20 (10.10)	10.00 (10.72)

Table A.22. Percentage of therapist statements containing each coding category of Persons Involved of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Patient	59.55 (11.97)	91.40 (4.85)	76.10 (7.31)	92.90 (0.85)	75.90 (12.08)	56.85 (38.69)
Therapist	11.98 (3.17)	5.95 (2.40)	5.53 (4.01)	12.93 (10.22)	13.45 (10.11)	18.15 (14.38)
Parent	1.27 (1.05)	1.18 (2.35)	1.60 (2.24)	5.98 (5.89)	30.48 (8.03)	27.18 (18.10)
Mate	2.10 (3.81)	13.35 (10.23)	0.60 (0.90)	1.78 (2.05)	4.32 (5.77)	25.80 (24.10)
Child	0.00 (0.00)	5.75 (5.99)	1.45 (2.28)	12.13 (9.34)	0.00 (0.00)	0.00 (0.00)
Dream/ Fantasy Figure	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	3.13 (2.89)
Acquaintance, Stranger Others in General	15.05 (6.19)	11.95 (9.74)	18.60 (14.54)	12.60 (3.68)	10.25 (13.55)	7.15 (14.30)

Table A.23. Mean number of therapist statements containing each coding category of Persons Involved of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patient	0.756 (0.164)	0.648 (0.136)
Therapist	0.078 (0.042)	0.161 (0.104)
Parent	0.013 (0.018)	0.213 (0.158)
Mate	0.054 (0.083)	0.106 (0.172)
Child	0.034 (0.069)	0.041 (0.078)
Dream/Fantasy Figure	0.000 (0.000)	0.010 (0.022)
Acquaintance/Strangers and Others in General	0.153 (0.102)	0.100 (0.107)

Table A.24. Mean number of therapist statements containing each coding category of Persons Involved of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Patient	0.595 (0.147)	0.915 (0.051)	0.760 (0.076)	0.963 (0.718)	0.763 (0.120)	0.820 (0.143)
Therapist	0.118 (0.031)	0.062 (0.028)	0.054 (0.038)	0.168 (0.083)	0.135 (0.102)	0.180 (0.143)
Parent	0.021 (0.038)	0.012 (0.024)	0.016 (0.023)	0.060 (0.059)	0.310 (0.080)	0.270 (0.182)
Mate	0.001 (0.003)	0.134 (0.103)	0.006 (0.009)	0.018 (0.021)	0.043 (0.057)	0.258 (0.243)
Child	0.000 (0.000)	0.085 (0.106)	0.014 (0.023)	0.123 (0.095)	0.000 (0.000)	0.000 (0.000)
Dream/ Fantasy Figure	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.031 (0.029)
Acquaintance, Stranger Others in General	0.152 (0.011)	0.119 (0.097)	0.188 (0.148)	0.125 (0.037)	0.102 (0.135)	0.073 (0.145)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements in which each person category was coded and the mean number of these codings. These tests showed Psychodynamic psychotherapies to contain significantly higher percentage and mean scores than did the Cognitive-behaviour therapies of therapist focus on the therapist ($t(22) = 2.079$, $p<0.05$ and $t(22) = 2.581$, $p<0.05$ respectively) and on parents ($t(22) = 4.367$, $p<0.001$ and $t(22) = 4.363$, $p<0.001$ respectively).

The Six Therapy Groups
A one-way ANOVA for the mean coding per therapist statement of references about the patient showed an overall significant effect of type of therapy ($F(5, 18) = 5.832$, $p<0.01$). Further analyses showed more such references were made in the Conversational psychotherapy group than in the Behaviour therapy group (Scheffe tests, $p<0.01$).

One-way ANOVAs for the percentage of therapist statements focusing on parents and the mean coding of these references showed overall significant effects of type of therapy ($F(5, 18) = 10.347$, $p<0.001$ and $F(5, 18) = 10.453$, $p<0.001$ respectively). A priori contrasts showed higher percentage and higher mean scores of therapist focus on parents in the Psychodynamic psychotherapy group than in the Behaviour ($t(18) = 4.831$, $p<0.001$ and $t(18) = 4.538$, $p<0.001$ respectively), Cognitive-behaviour ($t(18) = 4.847$, $p<0.001$ and $t(18) = 4.552$, $p<0.001$ respectively), Cognitive ($t(18) = 4.777$, $p<0.001$ and $t(18) = 4.486$, $p<0.001$ respectively) and Conversational ($t(18) = 4.053$, $p<0.001$ and $t(18) = 3.846$, $p<0.001$ respectively) therapy groups.

A one-way ANOVA for the percentage of therapist statements focusing on children showed an overall significant effect of type of therapy ($F(5, 18) = 4.449$, $p<0.01$). Further analyses however did not show a significant difference between any two of the six therapy groups.

One-way ANOVAs for the percentage of therapist statements focusing on dream or fantasy figures and the mean coding of these references showed overall significant effects of type of therapy ($F(5, 18) = 4.667$, $p<0.01$and $F(5, 18) = 4.676$, $p<0.001$ respectively). Further analyses showed higher percentage and higher mean scores in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe tests, $p<0.05$ and $p<0.05$ respectively), Cognitive-behaviour (Scheffe tests, $p<0.05$ and $p<0.05$ respectively), Cognitive (Scheffe tests, $p<0.05$ and $p<0.05$ respectively), Conversational (Scheffe tests, $p<0.05$ and $p<0.05$ respectively) and Psychodynamic groups (Scheffe tests, $p<0.05$ and $p<0.05$ respectively).

No other analyses of who therapists focus on showed any significant differences either across the two therapy groupings or the six therapy groups.

1.7 The Time Frame of Therapists' Interventions

The percentage of therapist statements within sessions in which each of the potential time frame categories was coded was analysed. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.25. Percentages are also presented for each of the six therapy groups in Table A.26.

The mean number of times per therapist statement each time frame was coded across the two therapy groupings is presented in Table A.27 and across the six therapy groups is presented in Table A.28.

The Two Therapy Groupings
Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements in which each time frame was coded and the mean number of these codings. These tests showed Psychodynamic psychotherapies to contain significantly higher percentage and mean scores than did the Cognitive-behaviour therapies of therapist focus on an in session time frame ($t(22) = 4.657$, $p<0.001$and $t(22) = 4.632$, $p<0.001$ respectively). The tests also showed the Cognitive-behaviour therapies to contain higher percentage and

mean scores of therapist focus on the future (t (21.999) = 2.417, $p<0.05$ and t (22) = 2.501, $p<0.05$ respectively) and on irrelevant or unspecified time frames (t (22) = 3.215, $p<0.005$ and t (22) = 3.210, $p<0.005$ respectively).

Table A.25. Percentage of therapist statements focusing on each of the Time Frames of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Pre-Adult Past	0.83 (2.38)	11.15 (18.03)
Adult Past	6.25 (11.81)	12.01 (16.81)
Current	28.67 (11.35)	28.60 (15.15)
In Session	8.26 (5.33)	36.75 (20.51)
Future	16.44 (10.16)	6.39 (10.21)
General	26.03 (15.97)	32.01 (19.70)
Irrelevant/Unspecified	19.37 (16.30)	3.65 (4.54)

Table A.26. Percentage of therapist statements focusing on each of the Time Frames of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic	
		Cog.-beh.	Conversational		Psychoanalytic
Coding Category					
Pre-Adult Past	0.45	0.00	2.05	4.48	19.08	9.93
	(0.90)	(0.00)	(4.10)	(6.13)	(28.76)	(13.50)
Adult Past	12.83	2.53	3.40	6.92	15.20	13.90
	(20.83)	(1.82)	(3.13)	(4.80)	(13.70)	(27.80)
Current	18.95	29.05	38.00	29.08	17.53	39.20
	(10.98)	(2.90)	(10.06)	(13.06)	(13.56)	(13.15)
In Session	10.80	2.28	11.70	25.70	27.90	56.65
	(2.90)	(1.12)	(4.74)	(11.62)	(9.77)	(22.73)
Future	14.65	23.73	10.95	12.98	6.20	0.00
	(11.44)	(10.77)	(4.05)	(15.54)	(5.34)	(0.00)
General	10.33	44.25	23.53	38.00	34.80	23.23
	(6.76)	(5.25)	(9.05)	(8.02)	(21.67)	(26.97)
Irrelevant/Unspecified	37.53	4.70	15.88	2.43	8.55	0.00
	(14.38)	(2.71)	(4.23)	(2.24)	(4.35)	(0.00)

Table A.27. Mean of each coding category of Time Frames of the Coding System of Therapeutic Focus contained in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Pre-Adult Past	0.008 (0.024)	0.112 (0.181)
Adult Past	0.063 (0.118)	0.121 (0.169)
Current	0.290 (0.116)	0.286 (0.152)
In Session	0.084 (0.055)	0.368 (0.205)
Future	0.168 (0.102)	0.064 (0.102)
General	0.264 (0.163)	0.320 (0.197)
Irrelevant/Unspecified	0.194 (0.163)	0.037 (0.046)

Table A.28. Mean of each coding category of Time Frames of the Coding System of Therapeutic Focus contained in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Pre-Adult Past	0.004	0.000	0.021	0.045	0.191	0.100
	(0.009)	(0.000)	(0.041)	(0.061)	(0.289)	(0.137)
Adult Past	0.128	0.025	0.034	0.069	0.153	0.140
	(0.203)	(0.018)	(0.031)	(0.048)	(0.138)	(0.280)
Current	0.201	0.290	0.038	0.290	0.175	0.392
	(0.128)	(0.032)	(0.102)	(0.131)	(0.135)	(0.134)
In Session	0.110	0.023	0.118	0.258	0.278	0.568
	(0.031)	(0.011)	(0.048)	(0.112)	(0.097)	(0.228)
Future	0.147	0.238	0.120	0.130	0.062	0.000
	(0.114)	(0.108)	(0.054)	(0.155)	(0.054)	(0.000)
General	0.101	0.445	0.025	0.380	0.347	0.233
	(0.066)	(0.053)	(0.104)	(0.081)	(0.216)	(0.270)
Irrelevant/Unspecified	0.375	0.470	0.160	0.024	0.086	0.000
	(0.145)	(0.027)	(0.041)	(0.022)	(0.045)	(0.000)

The Six Therapy Groups

One-way ANOVAs for the percentage of therapist statements focusing on an in session time frame and the mean coding of these references showed overall significant effects of type of therapy ($F(5, 18) = 11.505$, $p<0.001$ and $F(5, 18) = 11.560$, $p<0.001$ respectively). A priori contrasts showed higher percentage and mean scores of therapist focus on an in-session time frame in the Psychodynamic psychotherapy group than in the Cognitive-behaviour therapy group ($t(18) = 3.180$, $p<0.005$ and $t(18) = 2.561$, $p<0.05$ respectively) and a higher percentage score than in the Behaviour therapy group ($t(18) = 2.122$, $p<0.05$). A further series of a priori contrasts also showed higher percentage and mean scores in the Psychoanalytic psychotherapy group than in the Behaviour ($t(18) = 5.689$, $p<0.001$ and $t(18) = 5.942$,

$p<0.001$ respectively), Cognitive-behaviour ($t(18) = 6.747$, $p<0.001$ and $t(18) = 6.960$, $p<0.001$ respectively), Cognitive ($t(18) = 5.577$, $p<0.001$ and $t(18) = 5.847$, $p<0.001$ respectively), Conversational ($t(18) = 3.840$, $p<0.001$ and $t(18) = 5.235$, $p<0.001$ respectively) and Psychodynamic ($t(18) = 3.567$, $p<0.005$ and $t(18) = 4.398$, $p<0.005$ respectively) therapy groups.

One-way ANOVAs for the percentage of therapist statements focusing on a future time frame and for the mean coding of the future time frame showed overall significant effects of type of therapy ($F(5, 18) = 2.90$, $p<0.05$ and $F(5, 18) = 2.834$, $p<0.05$). However, Scheffe tests did not show significant differences between any two groups on either.

One-way ANOVAs for the percentage of therapist statements focusing on an irrelevant or unspecified time frame and for the mean occurrence of these references showed overall significant effects of type of therapy ($F(5, 18) = 18.129$, $p<0.001$and $F(5, 18) = 17.764$, $p<0.001$ respectively). Further analyses showed higher percentage and mean scores in the Behaviour therapy group than in the Cognitive-behaviour (Scheffe tests, $p<0.001$ and $p<0.001$), Cognitive (Scheffe tests, $p<0.01$ and $p<0.001$), Conversational (Scheffe tests, $p<0.001$ and $p<0.001$), Psychodynamic (Scheffe tests, $p<0.001$ and $p<0.001$) and Psychoanalytic (Scheffe tests, $p<0.001$ and $p<0.001$) therapy groups.

No other analyses of the time frames therapists focused on showed any significant differences either across the two therapy groupings or the six therapy groups.

1.8 Person Links and Time Links

The percentage of therapist statements within sessions in which links were made between time frames and in which links were made between persons was analysed. Mean percentages of these time links and person links are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.29. Percentages are also presented for each of the six therapy groups in Table A.30.

The mean number of times per therapist statement that links were made between time frames and links were made between person categories is presented for across the two therapy groupings in Table A.31 and for across the six therapy groups in Table A.32.

Table A.29. Percentage of therapist statements focusing on Time Links and Person Links of the Coding System of Therapeutic Focus across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Time Links	1.10 (1.30)	23.55 (17.92)
Person Links	0.93 (1.49)	13.18 (14.89)

Table A.30. Percentage of therapist statements focusing on Time Links and Person Links of the Coding System of Therapeutic Focus across the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Time Links	0.95	0.20	2.15	11.55	17.13	41.98
	(1.10)	(0.40)	(1.51)	(6.78)	(10.32)	(18.03)
Person Links	0.08	0.40	2.30	3.95	10.38	25.20
	(0.15)	(0.80)	(1.90)	(1.63)	(8.34)	(20.58)

Table A.31. Mean Time Links and Person Links of the Coding System of Therapeutic Focus contained in therapist statements across the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Time Links	0.011 (0.013)	0.236 (0.180)
Person Links	0.009 (0.015)	0.132 (0.149)

Table A.32. Mean Time Links and Person Links of the Coding System of Therapeutic Focus contained in therapist statements across the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Time Links	0.009	0.002	0.022	0.116	0.172	0.420
	(0.011)	(0.001)	(0.015)	(0.070)	(0.104)	(0.182)
Person Links	0.001	0.004	0.023	0.039	0.103	0.253
	(0.001)	(0.008)	(0.019)	(0.016)	(0.083)	(0.206)

The Two Therapy Groupings

Independent Samples t-Tests were used to compare the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapists' statements in which time links and person links were coded and the mean number of these codings. These tests showed Psychodynamic psychotherapies to contain significantly higher percentage and mean scores than did Cognitive-behaviour therapies of therapists' time links ($t(22) = 4.329$, $p<0.001$ and $t(22) = 4.325$, $p<0.001$ respectively) and person links ($t(22) = 2.836$, $p<0.01$ and $t(22) = 2.830$, $p<0.01$ respectively).

The Six Therapy Groups

One-way ANOVAs for the percentage of therapist statements containing time links and for the mean occurrence of these showed overall significant effects of type of therapy ($F(5, 18) = 12.792$, $p<0.001$ and $F(5, 18) = 12.531$, $p<0.001$ respectively). A priori contrasts showed higher percentage and mean scores of therapists' time links in the Psychoanalytic psychotherapy group than in the Behaviour (Scheffe tests, $p<0.001$ and $p<0.001$ respectively), Cognitive-behaviour (Scheffe tests, $p<0.001$ and $p<0.001$ respectively), Cognitive (Scheffe tests, $p<0.001$ and $p<0.001$ respectively) and Conversational (Scheffe tests, $p<0.01$ and $p<0.01$ respectively) therapy groups.

One-way ANOVAs also showed overall significant effects of type of therapy for the percentage of therapist statements containing person links ($F(5, 18) = 4.468$, $p<0.01$) and for the mean coding per therapist statement of person links ($F(5, 18) = 4.477$, $p<0.01$). However, further analyses did not show a significant difference between any two of the six therapy groups on either of these measures.

No other analyses of the linking of time frames or of person categories showed any significant differences either across the two therapy groupings or the six therapy groups.

2. Comparison of Coding Categories across Early and Late Sessions and by Type of Therapy

2.1 Components of Patient Functioning

The percentage of statements within sessions in which each category of components of patient functioning was focused on by therapists was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.33. Percentages are also presented for each of the six therapy groups in Table A.34.

The mean number of times per therapist statement each category of components of patient functioning was focused on by therapists across the two therapy groupings is presented in Table A.35 and across the six therapy groups is presented in Table A.36.

The rate of therapists' focus on each component of patient functioning was analysed across early and late sessions and the six therapy groups. Mean ratings of each of these categories is presented in Table A.37.

The Two Therapy Groupings

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements in which the various components of patient functioning were referred to and the mean occurrence of such references. These analyses showed no significant effect of session order or of the interaction of session order and type of therapy on any component of patient functioning. There were however significant effects of type of therapy on the percentage and mean measures of various components of patient functioning and these replicated the findings from independent samples t-Tests reported above (see page 384).

The percentage of statements containing references to thoughts, and the mean number of references per statement to thoughts were lower in late sessions of the Cognitive-behaviour grouping of therapies than in early sessions, but these were not significant ($t(5) = 2.659$, $p<0.05$ and $t(5) = 2.900$, $p<0.05$ respectively).

The Six Therapy Groups

Two-way repeated measure ANOVAs with one within-subjects factor (session order) and with one between-subjects factor (type of therapy) compared across the six therapy groups the percentage of therapist statements containing references to components of patient functioning, and the mean occurrence and rate of such references. These analyses showed no significant effect of session order or of the interaction of session order and type of therapy on components of patient functioning. There were however significant effects of type of therapy on the percentage, mean and rate measures of various components of patient functioning and these replicated the findings from one-way ANOVAs reported above (see pages 386-387).

A series of paired samples t-Tests showed the percentage of statements containing references to actions to be higher in late sessions over early of the Cognitive-behaviour therapy group ($t(1) = 71.000$, $p<0.01$) and references to self evaluation to be lower in late sessions over early of the Cognitive therapy group ($t(1) = 143.000$, $p<0.005$).

No other analyses of therapist focus on components of patient functioning showed a significant effect of session order or the interaction of session order and type of therapy.

Table A.33. Percentage of therapist statements across early and late sessions and by the two therapy groupings containing each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category				
Situation (E)	11.85	(10.31)	6.42	(7.51)
(L)	15.98	(8.98)	0.83	(1.29)
Self Observation (E)	7.90	(7.53)	20.25	(25.37)
(L)	4.83	(3.17)	11.77	(11.80)
Self Evaluation (E)	6.45	(6.08)	7.50	(7.75)
(L)	3.80	(4.07)	6.72	(9.15)
Expectations (E)	2.26	(1.43)	4.48	(4.47)
(L)	1.85	(1.62)	9.72	(8.39)
General Thoughts (E)	21.60	(11.46)	26.08	(26.71)
(L)	7.10	(5.61)	24.63	(12.48)
Intentions (E)	2.42	(2.74)	0.82	(1.49)
(L)	3.78	(2.66)	3.57	(5.66)
Emotions (E)	18.70	(8.42)	48.47	(24.30)
(L)	11.32	(6.52)	0.53	(0.25)
Actions (E)	17.88	(8.64)	23.73	(23.69)
(L)	21.77	(6.50)	10.93	(9.00)

Table A.34. Percentage of therapist statements across early and late sessions and by the six therapy groups containing each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Situation (E)	1.45	22.45	11.65	4.90	8.80	5.55
	(0.35)	(8.13)	(4.88)	(6.93)	(12.45)	(7.85)
(L)	21.15	14.55	(12.25)	0.00	2.50	0.00
	(14.21)	(10.53)	(2.33)	(0.00)	(0.14)	(0.00)
Self Observation (E)	3.50	3.20	17.00	4.30	6.45	50.00
	(3.25)	(4.53)	(1.98)	(0.85)	(0.78)	(23.62)
(L)	3.50	6.90	4.10	4.75	3.75	26.80
	(4.24)	(4.24)	(0.99)	(2.90)	(1.63)	(2.55)
Self Evaluation (E)	0.90	5.55	12.90	4.65	6.75	11.10
	(0.42)	(1.20)	(6.08)	(1.34)	(2.90)	(15.70)
(L)	0.00	5.57	5.75	3.90	3.75	12.50
	(0.00)	(1.34)	(6.15)	(1.70)	(1.62)	(17.68)
Expectations (E)	1.35	2.50	2.95	6.75	1.15	5.50
	(0.64)	(1.84)	(1.91)	(0.92)	(1.63)	(7.85)
(L)	0.00	2.45	3.10	6.60	10.05	12.50
	(0.00)	(1.20)	(0.99)	(2.12)	(0.35)	(17.68)
General Thoughts (E)	17.45	26.60	20.75	21.20	57.05	0.00
	(18.03)	(12.30)	(9.69)	(4.10)	(14.92)	(0.00)
(L)	1.10	8.90	11.30	11.35	28.60	33.95
	(0.28)	(6.36)	(1.70)	(0.78)	(7.78)	(12.66)
Intentions (E)	0.85	3.15	3.25	2.45	0.00	0.00
	(1.20)	(2.76)	(4.60)	(1.77)	(0.00)	(0.00)
(L)	2.75	3.05	5.55	3.55	0.00	7.15
	(3.89)	(1.20)	(3.04)	(2.62)	(0.00)	(10.11)
Emotions (E)	11.55	23.60	20.95	52.40	20.75	72.25
	(7.14)	(11.60)	(2.90)	(13.86)	(0.21)	(7.85)
(L)	7.10	18.90	7.95	38.75	43.45	58.95
	(2.83)	(3.39)	(4.46)	(24.25)	(17.89)	(22.70)
Actions (E)	15.75	19.90	18.00	15.35	5.85	50.00
	(12.23)	(11.88)	(8.06)	(4.45)	(8.27)	(23.62)
(L)	22.20	23.45	19.55	11.85	1.30	19.65
	(7.21)	(11.95)	(0.92)	(2.33)	(1.84)	(7.57)

Table A.35. Mean number of each coding category of components of patient functioning of the Coding System of Therapist Focus in therapist statements across early and late sessions and by the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Situation (E)	0.119 (0.103)	0.067 (0.077)
(L)	0.160 (0.089)	0.022 (0.044)
Self Observation (E)	0.079 (0.075)	0.202 (0.225)
(L)	0.050 (0.031)	0.132 (0.126)
Self Evaluation (E)	0.069 (0.071)	0.066 (0.079)
(L)	0.038 (0.040)	0.107 (0.100)
Expectations (E)	0.025 (0.015)	0.039 (0.044)
(L)	0.020 (0.015)	0.102 (0.079)
General Thoughts (E)	0.221 (0.113)	0.262 (0.302)
(L)	0.079 (0.049)	0.215 (0.172)
Intentions (E)	0.024 (0.027)	0.013 (0.020)
(L)	0.038 (0.026)	0.012 (0.022)
Emotions (E)	0.197 (0.094)	0.405 (0.271)
(L)	0.132 (0.060)	0.533 (0.249)
Actions (E)	0.185 (0.087)	0.256 (0.229)
(L)	0.227 (0.077)	0.137 (0.133)

Table A.36. Mean number of each coding category of components of patient functioning of the Coding System of Therapist Focus in therapist statements across early and late sessions and by the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Situation (E)	0.015	0.225	0.116	0.055	0.090	0.055
	(0.004)	(0.078)	(0.048)	(0.078)	(0.127)	(0.078)
(L)	0.210	0.145	0.125	0.000	0.012	0.055
	(0.141)	(0.105)	(0.021)	(0.000)	(0.017)	(0.078)
Self Observation (E)	0.035	0.032	0.170	0.043	0.064	0.500
	(0.033)	(0.045)	(0.014)	(0.008)	(0.008)	(0.240)
(L)	0.035	0.069	0.046	0.047	0.059	0.290
	(0.043)	(0.042)	(0.004)	(0.029)	(0.015)	(0.057)
Self Evaluation (E)	0.009	0.056	0.144	0.035	0.053	0.110
	(0.004)	(0.012)	(0.080)	(0.029)	(0.009)	(0.156)
(L)	0.000	0.057	0.057	0.039	0.048	0.235
	(0.000)	(0.013)	(0.060)	(0.017)	(0.002)	(0.021)
Expectations (E)	0.013	0.025	0.038	0.049	0.012	0.055
	(0.006)	(0.019)	(0.016)	(0.032)	(0.016)	(0.078)
(L)	0.005	0.024	0.031	0.066	0.060	0.180
	(0.007)	(0.012)	(0.010)	(0.021)	(0.053)	(0.099)
General Thoughts (E)	0.174	0.265	0.225	0.170	0.615	0.000
	(0.179)	(0.120)	(0.092)	(0.099)	(0.205)	(0.000)
(L)	0.034	0.087	0.115	0.115	0.405	0.125
	(0.030)	(0.061)	(0.021)	(0.007)	(0.091)	(0.177)
Intentions (E)	0.009	0.032	0.032	0.038	0.000	0.000
	(0.012)	(0.028)	(0.046)	(0.001)	(0.000)	(0.000)
(L)	0.025	0.031	0.058	0.036	0.000	0.000
	(0.036)	(0.012)	(0.027)	(0.026)	(0.000)	(0.000)
Emotions (E)	0.117	0.235	0.240	0.270	0.220	0.725
	(0.074)	(0.120)	(0.071)	(0.226)	(0.014)	(0.078)
(L)	0.115	0.200	0.082	0.415	0.420	0.765
	(0.035)	(0.014)	(0.040)	(0.276)	(0.269)	(0.021)
Actions (E)	0.160	0.205	0.190	0.190	0.075	0.500
	(0.127)	(0.120)	(0.071)	(0.001)	(0.106)	(0.240)
(L)	0.230	0.250	0.200	0.120	0.000	0.290
	(0.085)	(0.141)	(0.141)	(0.028)	(0.000)	(0.057)

Table A.37. The mean rate of therapist references to each coding category of Components of Patient Functioning of the Coding System of Therapeutic Focus across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category						
Situation (E)	0.011	0.069	0.033	0.021	0.053	0.050
	(0.002)	(0.003)	(0.018)	(0.029)	(0.074)	(0.070)
(L)	0.135	0.051	0.051	0.000	0.005	0.038
	(0.097)	(0.017)	(0.007)	(0.000)	(0.008)	(0.054)
Self Observation (E)	0.027	0.013	0.047	0.017	0.036	0.401
	(0.024)	(0.018)	(0.011)	(0.001)	(0.002)	(0.146)
(L)	0.023	0.025	0.019	0.016	0.029	0.215
	(0.028)	(0.005)	(0.002)	(0.005)	(0.010)	(0.022)
Self Evaluation (E)	0.007	0.019	0.038	0.015	0.030	0.099
	(0.003)	(0.009)	(0.016)	(0.014)	(0.007)	(0.140)
(L)	0.000	0.023	0.023	0.014	0.023	0.177
	(0.000)	(0.005)	(0.024)	(0.002)	(0.002)	(0.033)
Expectations (E)	0.011	0.009	0.010	0.021	0.006	0.050
	(0.006)	(0.009)	(0.006)	(0.017)	(0.009)	(0.070)
(L)	0.003	0.009	0.013	0.026	0.028	0.138
	(0.004)	(0.001)	(0.004)	(0.016)	(0.022)	(0.087)
General Thoughts (E)	0.131	0.080	0.064	0.073	0.347	0.000
	(0.131)	(0.013)	(0.035)	(0.050)	(0.137)	(0.000))
(L)	0.021	0.042	0.047	0.043	0.200	0.100
	(0.018)	(0.042)	(0.007)	(0.011)	(0.067)	(0.141)
Intentions (E)	0.006	0.012	0.010	0.016	0.000	0.000
	(0.009)	(0.012)	(0.014)	(0.002)	(0.000)	(0.000)
(L)	0.015	0.014	0.023	0.015	0.000	0.000
	(0.022)	(0.011)	(0.010)	(0.014)	(0.000)	(0.000)
Emotions (E)	0.090	0.070	0.065	0.117	0.123	0.603
	(0.052)	(0.016)	(0.009)	(0.108)	(0.001)	(0.141)
(L)	0.072	0.085	0.033	0.142	0.198	0.573
	(0.018)	(0.043)	(0.018)	(0.056)	(0.109)	(0.039)
Actions (E)	0.122	0.061	0.054	0.078	0.044	0.401
	(0.091)	(0.019)	(0.028)	(0.010)	(0.062)	(0.146)
(L)	0.147	0.092	0.081	0.047	0.000	0.215
	(0.062)	(0.013)	(0.003)	(0.025)	(0.000)	(0.022)

2.2 General Interventions

The percentage of statements within sessions in which each category of general interventions was focused on by therapists was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.38. Percentages are also presented for each of the six therapy groups in Table A.39.

The mean number of times per therapist statement each category of general interventions was focused on by therapists in early and late sessions across the two therapy groupings is presented in Table A.40 and across the six therapy groups is presented in Table A.41.

The rate of therapists' focus on each general intervention in early and late sessions across the six therapy groups is presented in Table A.42.

Table A.38. Percentage of therapist statements across early and late sessions and the two therapy groupings containing each coding category of General Interventions of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Reality/Unreality (E)	10.10 (12.83)	12.97 (12.14)
(L)	9.02 (7.22)	11.20 (9.05)
Exp./Imag. Reaction (E)	6.08 (6.90)	8.85 (7.95)
(L)	3.67 (4.47)	18.68 (28.33)
Inst./Sig.Theme (E)	2.18 (2.43)	2.01 (2.88)
(L)	0.53 (0.68)	3.40 (3.07)
Therapist Support (E)	0.83 (0.71)	0.00 (0.00)
(L)	3.62 (1.94)	0.28 (0.69)
Information Giving (E)	0.75 (0.66)	0.00 (0.00)
(L)	1.32 (1.25)	0.00 (0.00)
Changes (E)	1.80 (1.10)	0.00 (0.00)
(L)	2.23 (1.84)	1.78 (3.03)
Avoidance (E)	1.03 (2.04)	18.23 (24.83)
(L)	0.32 (0.78)	7.23 (5.92)
Self Disclosure (E)	1.75 (2.91)	0.31 (0.78)
(L)	1.37 (0.71)	0.28 (0.69)

The Two Therapy Groupings

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements in which the various general interventions of the Coding System of Therapist Focus were referred to and the mean occurrence of such references. These analyses showed a significant effect of the interaction of session order and type of therapy on therapist provision of support ($F(1, 10) = 5.764$, $p<0.05$ and $F(1, 10) = 8.676$, $p<0.05$ respectively). The Cognitive-behaviour grouping of therapies had a higher level of supportive interventions which increased in late over early sessions whereas in the grouped Psychodynamic psychotherapies group they reduced in late sessions over early. There were also significant effects of type of therapy on measures of percentage and rate of components of general interventions which replicated the findings from independent samples t-Tests reported above (see pages 387-388).

Paired samples t-Tests showed late sessions of the Cognitive-behaviour grouping to contain a higher measures of percentage and mean of giving support than did early sessions ($t(5) = 2.788$, $p<0.05$ and $t(5) = 2.805$, $p<0.05$).

Table A.39. Percentage of therapist statements across early and late sessions and the six therapy groups containing each coding category of General Interventions of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group		Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category							
Reality/Unreality	(E)	0.30	8.75	21.25	7.05	4.10	27.750
		(0.42)	(5.73)	(18.60)	(2.05)	(2.55)	(7.84)
	(L)	1.85	9.30	15.90	11.50	2.45	19.65
		(2.62)	(6.93)	(2.83)	(6.65)	(3.46)	(7.57)
Exp./Imag. Reaction	(E)	2.05	6.00	10.20	4.65	16.35	5.55
		(0.49)	(4.81)	(12.16)	(6.58)	(6.43)	(7.85)
	(L)	0.45	2.35	8.20	3.55	15.00	37.50
		(0.64)	(3.32)	(4.81)	(2.62)	(0.57)	(53.03)
Inst./Sig. Theme	(E)	0.00	3.80	2.75	4.90	1.15	0.00
		(0.00)	(3.68)	(0.78)	(3.54)	(1.63)	(0.00)
	(L)	0.00	1.35	0.25	3.90	6.30	0.00
		(0.00)	(0.35)	(0.35)	(1.70)	(1.98)	(0.00)
Therapist Support	(E)	1.45	0.65	0.55	0.00	0.00	0.00
		(0.35)	(0.92)	(0.78)	(0.00)	(0.00)	(0.00)
	(L)	3.55	2.75	4.55	0.85	0.00	0.00
		(0.49)	(3.89)	(0.35)	(1.20)	(0.00)	(0.00)
Information Giving	(E)	0.30	0.60	1.35	0.00	0.00	0.00
		(0.42)	(0.85)	(0.35)	(0.00)	(0.00)	(0.00)
	(L)	2.25	1.20	0.50	0.00	0.00	0.00
		(1.34)	(1.70)	(0.00)	(0.00)	(0.00)	(0.00)
Changes	(E)	1.15	1.85	2.40	0.00	0.00	0.00
		(1.63)	(0.78)	(1.13)	(0.00)	(0.00)	(0.00)
	(L)	1.60	2.20	2.90	1.70	3.65	0.00
		(2.26)	(3.11)	(0.71)	(2.40)	(5.16)	(0.00)
Avoidance	(E)	0.00	2.55	0.55	5.85	4.10	44.75
		(0.00)	(3.61)	(0.78)	(0.35)	(2.55)	(31.04)
	(L)	0.00	0.00	0.95	9.65	4.90	7.15
		(0.00)	(0.00)	(1.34)	(1.63)	(6.93)	(10.11)
Self Disclosure	(E)	4.10	0.60	0.55	0.95	0.00	0.00
		(4.95)	(0.85)	(0.78)	(1.34)	(0.00)	(0.00)
	(L)	2.00	1.35	0.75	0.85	0.00	0.00
		(0.85)	(0.35)	(0.35)	(1.20)	(0.00)	(0.00)

The Six Therapy Groups

Two-way repeated measure ANOVAs with one within-subjects factor (session order) and with one between-subjects factor (type of therapy) compared across the six therapy groups the percentage of therapist statements containing references to general interventions, and the mean occurrence and rate of such references. These analyses showed a significant increase in the percentage of therapist statements offering support in late sessions over early ($F(1,6) = 6.443$, $p<0.05$). There were also significant effects of type of therapy on the percentage, mean and rate measures of various components of general interventions and these replicated the findings from one-way ANOVAs reported above (see pages 389).

No other analyses of therapist focus on components of general interventions showed a significant effect of the interaction of session order and type of therapy.

Table A.40. Mean number of each coding category of General Interventions of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Reality/Unreality (E)	0.101 (0.127)	0.115 (0.119)
(L)	0.090 (0.072)	0.128 (0.095)
Exp./Imag. Reaction (E)	0.063 (0.073)	0.109 (0.067)
(L)	0.037 (0.046)	0.215 (0.271)
Inst./Sig. Theme (E)	0.022 (0.024)	0.017 (0.029)
(L)	0.005 (0.007)	0.025 (0.022)
Therapist Support (E)	0.009 (0.007)	0.008 (0.020)
(L)	0.036 (0.019)	0.003 (0.007)
Information Giving (E)	0.007 (0.007)	0.001 (0.002)
(L)	0.013 (0.013)	0.000 (0.000)
Changes (E)	0.018 (0.011)	0.004 (0.010)
(L)	0.022 (0.018)	0.018 (0.030)
Avoidance (E)	0.010 (0.021)	0.175 (0.254)
(L)	0.003 (0.008)	0.089 (0.077)
Self Disclosure (E)	0.017 (0.029)	0.005 (0.008)
(L)	0.014 (0.007)	0.003 (0.007)

Table A.41. Mean number of each coding category of General Interventions of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.		Conversational		Psychoanalytic
Coding Category							
Reality/Unreality	(E)	0.003	0.089	0.211	0.118	0.041	0.275
		(0.004)	(0.059)	(0.183)	(0.088)	(0.025)	(0.078)
	(L)	0.018	0.092	0.160	0.114	0.036	0.235
		(0.026)	(0.068)	(0.028)	(0.065)	(0.018)	(0.021)
Expected/Imagined	(E)	0.020	0.060	0.106	0.106	0.165	0.055
Reaction of Another		(0.004)	(0.048)	(0.130)	(0.019)	(0.064)	(0.078)
	(L)	0.005	0.024	0.084	0.036	0.180	0.430
		(0.007)	(0.033)	(0.051)	(0.026)	(0.042)	(0.453)
Instance/Significant	(E)	0.000	0.038	0.027	0.039	0.012	0.000
Theme		(0.000)	(0.037)	(0.008)	(0.049)	(0.016)	(0.000)
	(L)	0.000	0.013	0.002	0.039	0.036	0.000
		(0.000)	(0.003)	(0.003)	(0.017)	(0.018)	(0.000)
Therapist Support	(E)	0.015	0.006	0.005	0.024	0.000	0.000
		(0.004)	(0.009)	(0.008)	(0.034)	(0.000)	(0.000)
	(L)	0.036	0.027	0.046	0.008	0.000	0.000
		(0.005)	(0.039)	(0.004)	(0.012)	(0.000)	(0.000)
Information Giving	(E)	0.003	0.006	0.014	0.002	0.000	0.000
		(0.004)	(0.006)	(0.004)	(0.003)	(0.000)	(0.000)
	(L)	0.023	0.012	0.005	0.000	0.000	0.000
		(0.014)	(0.017)	(0.001)	(0.000)	(0.000)	(0.000)
Changes	(E)	0.012	0.018	0.024	0.012	0.000	0.000
		(0.016)	(0.008)	(0.011)	(0.017)	(0.000)	(0.000)
	(L)	0.016	0.022	0.029	0.017	0.036	0.000
		(0.023)	(0.031)	(0.007)	(0.024)	(0.052)	(0.000)
Avoidance	(E)	0.000	0.026	0.005	0.037	0.041	0.445
		(0.000)	(0.036)	(0.008)	(0.026)	(0.025)	(0.318)
	(L)	0.000	0.000	0.010	0.097	0.060	0.110
		(0.000)	(0.000)	(0.014)	(0.018)	(0.053)	(0.156)
Self Disclosure	(E)	0.041	0.006	0.005	0.014	0.000	0.000
		(0.050)	(0.008)	(0.008)	(0.006)	(0.000)	(0.000)
	(L)	0.020	0.013	0.007	0.008	0.000	0.000
		(0.009)	(0.003)	(0.003)	(0.012)	(0.000)	(0.000)

Table A.42. The mean rate of therapist references to each coding category of General Interventions of the Coding System of Therapeutic Focus across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.	Conversational		Psychoanalytic	
Coding Category							
Reality/Unreality	(E)	0.002	0.032	0.054	0.046	0.023	0.223
		(0.003)	(0.028)	(0.042)	(0.030)	(0.016)	(0.035)
	(L)	0.011	0.045	0.065	0.047	0.017	0.177
		(0.016)	(0.046)	(0.014)	(0.038)	(0.007)	(0.033)
Expected/Imagined	(E)	0.016	0.017	0.027	0.043	0.090	0.050
Reaction of Another		(0.005)	(0.010)	(0.031)	(0.002)	(0.029)	(0.070)
	(L)	0.003	0.013	0.035	0.015	0.089	0.338
		(0.004)	(0.018)	(0.022)	(0.014)	(0.030)	(0.370)
Instance/Significant	(E)	0.000	0.014	0.007	0.018	0.006	0.000
Theme		(0.000)	(0.016)	(0.001)	(0.022)	(0.009)	(0.000)
	(L)	0.000	0.006	0.001	0.014	0.017	0.000
		(0.000)	(0.004)	(0.001)	(0.002)	(0.007)	(0.000)
Therapist Support	(E)	0.011	0.003	0.002	0.009	0.000	0.000
		(0.002)	(0.004)	(0.002)	(0.013)	(0.000)	(0.000)
	(L)	0.023	0.008	0.019	0.003	0.000	0.000
		(0.004)	(0.011)	(0.002)	(0.004)	(0.000)	(0.000)
Information Giving	(E)	0.002	0.002	0.004	0.001	0.000	0.000
		(0.003)	(0.002)	(0.001)	(0.001)	(0.000)	(0.000)
	(L)	0.014	0.007	0.002	0.000	0.000	0.000
		(0.008)	(0.009)	(0.000)	(0.000)	(0.000)	(0.000)
Changes	(E)	0.009	0.006	0.007	0.005	0.000	0.000
		(0.012)	(0.001)	(0.004)	(0.006)	(0.000)	(0.000)
	(L)	0.010	0.006	0.012	0.005	0.016	0.000
		(0.014)	(0.009)	(0.002)	(0.007)	(0.023)	(0.000)
Avoidance	(E)	0.000	0.010	0.002	0.016	0.023	0.351
		(0.000)	(0.014)	(0.002)	(0.013)	(0.016)	(0.216)
	(L)	0.000	0.000	0.004	0.038	0.028	0.077
		(0.000)	(0.000)	(0.006)	(0.018)	(0.022)	(0.109)
Self Disclosure	(E)	0.034	0.002	0.002	0.006	0.000	0.000
		(0.042)	(0.002)	(0.002)	(0.003)	(0.000)	(0.000)
	(L)	0.013	0.006	0.003	0.003	0.000	0.000
		(0.006)	(0.004)	(0.001)	(0.004)	(0.000)	(0.000)

2.3 Intrapersonal Links

The percentage of statements within sessions in which each category of intrapersonal links was focused on by therapists was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.43. Percentages are also presented for each of the six therapy groups in Table A.44.

The mean number of times per therapist statement each category of intrapersonal links was focused on by therapists in early and late sessions across the two therapy groupings is presented in Table A.45 and across the six therapy groups is presented in Table A.46.

The rate of therapists' focus on each category of intrapersonal links in early and late sessions across the six therapy groups is presented in Table A.47.

Table A.43. Percentage of therapist statements across early and late sessions and the two therapy groupings containing each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group		Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category					
Similarity/Patterns	(E)	4.72	(3.58)	5.18	(8.47)
	(L)	1.70	(1.69)	7.85	(9.52)
Difference/Incongruity	(E)	2.55	(2.83)	2.02	(2.24)
	(L)	0.85	(0.96)	5.48	(5.76)
Vicious Circle	(E)	0.18	(0.45)	0.40	(0.98)
	(L)	0.13	(0.33)	0.00	(0.00)
Consequences	(E)	7.43	(6.49)	25.12	(22.98)
	(L)	3.48	(2.08)	18.43	(16.32)

Table A.44. Percentage of therapist statements across early and late sessions and the six therapy groups containing each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.	Conversational		Psychoanalytic	
Coding Category							
Similarity/ Patterns	(E)	1.30	8.50	4.35	1.85	2.60	11.10
		(0.99)	(2.97)	(1.48)	(2.62)	(0.42)	(15.70)
	(L)	0.45	3.45	1.20	2.20	8.85	12.50
		(0.64)	(1.77)	(0.99)	(0.71)	(5.59)	(17.68)
Difference/ Incongruity	(E)	0.15	5.60	1.90	3.70	2.35	0.00
		(0.21)	(2.97)	(0.42)	(0.01)	(3.32)	(0.00)
	(L)	0.25	1.10	1.20	1.70	7.60	7.15
		(0.35)	(1.56)	(0.99)	(2.40)	(3.82)	(10.11)
Vicious Cycle	(E)	0.00	0.00	0.55	1.20	0.00	0.00
		(0.00)	(0.00)	(0.78)	(1.70)	(0.00)	(0.00)
	(L)	0.00	0.40	0.00	0.00	0.00	0.00
		(0.00)	(0.57)	(0.00)	(0.00)	(0.00)	(0.00)
Consequences	(E)	0.75	14.55	7.00	17.45	7.90	50.00
		(0.64)	(4.31)	(0.71)	(11.53)	(1.27)	(23.62)
	(L)	1.85	5.50	3.10	10.60	12.50	32.15
		(2.62)	(0.01)	(0.99)	(11.24)	(0.42)	(25.24)

Table A.45. Mean number of each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group		Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category			
Similarity/Patterns	(E)	0.048 (0.037)	0.046 (0.086)
	(L)	0.017 (0.017)	0.098 (0.107)
Difference/Incongruity	(E)	0.026 (0.028)	0.015 (0.021)
	(L)	0.008 (0.010)	0.022 (0.024)
Vicious Circle	(E)	0.002 (0.004)	0.000 (0.000)
	(L)	0.001 (0.003)	0.000 (0.000)
Consequences	(E)	0.080 (0.067)	0.212 (0.248)
	(L)	0.035 (0.021)	0.206 (0.179)

Table A.46. Mean number of each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.		Conversational		Psychoanalytic
Coding Category							
Similarity/ Patterns	(E)	0.013 (0.010)	0.087 (0.032)	0.043 (0.015)	0.002 (0.000)	0.264 (0.004)	0.110 (0.156)
	(L)	0.005 (0.007)	0.035 (0.018)	0.012 (0.010)	0.022 (0.007)	0.036 (0.018)	0.235 (0.021)
Difference/ Incongruity	(E)	0.001 (0.002)	0.056 (0.029)	0.019 (0.004)	0.021 (0.023)	0.023 (0.033)	0.000 (0.000)
	(L)	0.002 (0.003)	0.011 (0.016)	0.012 (0.010)	0.017 (0.024)	0.048 (0.002)	0.000 (0.000)
Vicious Cycle	(E)	0.000 (0.000)	0.000 (0.000)	0.005 (0.008)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)
	(L)	0.000 (0.000)	0.004 (0.006)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)
Consequences	(E)	0.007 (0.006)	0.150 (0.042)	0.082 (0.001)	0.058 (0.048)	0.079 (0.013)	0.500 (0.240)
	(L)	0.018 (0.026)	0.055 (0.001)	0.031 (0.010)	0.109 (0.115)	0.095 (0.035)	0.415 (0.120)

Table A.47. The mean rate of therapist references to each coding category of Intrapersonal Links of the Coding System of Therapeutic Focus across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.		Conversational		Psychoanalytic
Coding Category							
Similarity/ Patterns	(E)	0.010 (0.007)	0.027 (0.002)	0.012 (0.006)	0.001 (0.001)	0.015 (0.003)	0.099 (0.140)
	(L)	0.003 (0.004)	0.016 (0.014)	0.005 (0.004)	0.009 (0.005)	0.017 (0.007)	0.176 (0.033)
Difference/ Incongruity	(E)	0.001 (0.002)	0.020 (0.015)	0.005 (0.002)	0.009 (0.011)	0.012 (0.017)	0.000 (0.000)
	(L)	0.001 (0.002)	0.003 (0.004)	0.005 (0.004)	0.005 (0.007)	0.023 (0.002)	0.000 (0.000)
Vicious Cycle	(E)	0.000 (0.000)	0.000 (0.000)	0.002 (0.002)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)
	(L)	0.000 (0.000)	0.002 (0.003)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)
Consequences	(E)	0.006 (0.005)	0.047 (0.001)	0.023 (0.003)	0.025 (0.023)	0.044 (0.010)	0.401 (0.146)
	(L)	0.011 (0.016)	0.023 (0.010)	0.013 (0.004)	0.035 (0.031)	0.045 (0.012)	0.315 (0.120)

The Two Therapy Groupings

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements containing intrapersonal links and the mean occurrence of such references. There was no significant effect of session order or of the interaction of session order and type of therapy on any category of intrapersonal links. The grouped Psychodynamic psychotherapies had higher percentage and mean scores of therapist focus on intrapersonal consequences and this replicated the finding from independent samples t-Tests reported above (see page 391).

The Six Therapy Groups

A two-way repeated measure ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the six therapy groups with respect to the percentage of therapist statements in which the various intrapersonal links were referred to, and the mean occurrence and rate of references. The analyses showed a significant decrease in the percentage of therapist statements containing references to intrapersonal consequences in late sessions over early ($F(1, 6) = 54.028$, $p<0.001$) and that this session order effect showed a significant interaction with type of therapy ($F(5, 6) = 20.053$, $p<0.001$). Further analyses of the interaction showed:

i) a significant effect of session order between the Cognitive and the Psychoanalytic groups ($F(1, 2) = 171.244$, $p< 0.01$). The Cognitive group had a lower level of references to intrapersonal consequences in both early and late sessions than the Psychoanalytic group and both groups saw a reduction in such references in late sessions over early.

ii) a significant effect of session order and of the interaction of session order and therapy group between the Conversational and Psychoanalytic groups ($F(1, 2) = 445.961$, $p<0.01$ and ($F(1, 2) = 89.617$, $p<0.01$ respectively). The Conversational group had a lower level of references to intrapersonal consequences in both early and late sessions than the Psychoanalytic group and both groups saw a reduction in such references in late sessions over early.

iii) a significant effect of the interaction of session order and therapy group between the Psychodynamic and Psychoanalytic groups ($F(1, 2) = 182.444$, $p<0.005$). The Psychodynamic group had a lower level of references to intrapersonal consequences in both early and late sessions than did the Psychoanalytic group but whereas these references increased in late sessions over early in Psychodynamic psychotherapy they decreased in psychoanalytic sessions.

iv) a significant effect of the interaction of session order and type of therapy between the Conversational and Psychodynamic psychotherapy groups ($F(1, 2) = 87.811$, $p<0.01$). The Conversational psychotherapy group had a higher level of references to intrapersonal consequences than the Psychodynamic group in early session. The level of such references decreased in late over early sessions of the Conversational group and increased in the Psychodynamic group so that in late sessions the Psychodynamic group had a higher level of references than the conversational.

There were also significant effects of type of therapy on the percentage, mean and rate measures of various components of intrapersonal links and these replicated the findings from one-way ANOVAs reported above (see page 391).

No other analyses of therapist focus on intrapersonal links showed a significant effect of the interaction of session order and type of therapy.

2.4 Interpersonal Links

The percentage of statements within sessions in which each category of interpersonal links was focused on by therapists was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.48. Percentages are also presented for each of the six therapy groups in Table A.49.

The mean number of times per therapist statement each category of interpersonal links was focused on by therapists across the two therapy groupings is presented in Table A.50 and across the six therapy groups is presented in Table A.51.

The rate of therapists' focus on each category of interpersonal links was analysed across early and late sessions and the six therapy groups. Mean rates of each of these categories is presented in Table A.52.

The Two Therapy Groupings and the Six Therapy Groups

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements containing interpersonal links and the mean occurrence of such references. Further two-way ANOVAs also compared the six therapy groups with respect to the percentage of therapist statements in which the various interpersonal links were referred to, and the mean occurrence and rate of such references. The analyses did not show any significant

effect of session order or of the interaction of session order and type of therapy on any category of interpersonal links. They did however show effects of type of therapy which replicated those found with independent samples t-Tests and with one-way ANOVAs reported above (see pages 392-394).

Table A.48. Percentage of therapist statements across early and late sessions and the two therapy groupings containing each coding category of Interpersonal Links of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding Category				
Patterns (E)	2.05	(2.76)	3.98	(4.92)
(L)	0.65	(1.59)	6.17	(5.69)
Vicious Cycle (E)	0.00	(0.00)	0.00	(0.00)
(L)	0.00	(0.00)	1.72	(4.20)
Consequences (E)	2.47	(2.77)	7.00	(8.25)
(L)	1.62	(0.83)	4.80	(4.49)
Dir.of con.:pt. to oth. (E)	0.00	(0.00)	2.47	(4.48)
(L)	0.27	(0.45)	1.53	(1.98)
Dir.of con.:oth. to pt (E)	2.47	(2.47)	4.53	(4.78)
(L)	1.35	(0.93)	3.27	(3.30)
Compares/Contrasts (E)	1.67	(3.28)	0.20	(0.49)
(L)	1.58	(1.51)	(1.28)	(1.41)
General Interaction (E)	2.62	(2.48)	3.35	(4.40)
(L)	1.80	(2.01)	4.18	(5.64)

Table A.49. Percentage of therapist statements across early and late sessions and the six therapy groups containing each coding category of Interpersonal Links of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.		Conversational		Psychoanalytic
Coding Category							
Patterns	(E)	0.30	4.20	1.65	5.25	1.15	5.55
		(0.42)	(4.10)	(2.33)	(5.73)	(1.63)	(7.85)
	(L)	0.00	1.95	0.00	2.55	8.80	7.15
		(0.00)	(2.76)	(0.00)	(3.61)	(2.12)	(10.11)
Vicious Cycle	(E)	0.00	0.00	0.00	0.00	0.00	0.00
		(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
	(L)	0.00	0.00	0.00	0.00	5.15	0.00
		(0.00)	(0.00)	(0.00)	(0.00)	(7.28)	(0.00)
Consequences	(E)	1.75	4.85	0.80	5.25	4.65	11.10
		(2.47)	(3.18)	(1.13)	(0.49)	(6.58)	(15.70)
	(L)	1.10	2.30	1.45	5.60	8.80	0.00
		(0.28)	(0.14)	(1.34)	(4.10)	(2.12)	(0.00)
Dir. of con. pt. to oth.	(E)	0.00	0.00	0.00	1.85	0.00	5.55
		(0.00)	(0.00)	(0.00)	(2.62)	(0.00)	(7.85)
	(L)	0.00	0.55	0.25	0.85	3.75	0.00
		(0.00)	(0.78)	(0.35)	(1.20)	(1.63)	(0.00)
Dir. of con. oth. to pt.	(E)	1.75	4.85	0.80	3.40	4.65	5.55
		(2.47)	(3.18)	(1.13)	(2.12)	(6.58)	(7.85)
	(L)	1.10	1.75	1.20	4.75	5.05	0.00
		(0.28)	(0.92)	(1.70)	(2.90)	(3.75)	(0.00)
Compares/Contrasts	(E)	0.30	2.55	2.15	0.60	0.00	0.00
		(0.42)	(3.61)	(0.78)	(0.85)	(0.00)	(0.00)
	(L)	1.10	1.95	1.70	1.35	2.50	0.00
		(0.28)	(2.76)	(1.70)	(1.91)	(0.14)	(0.00)
General Interaction	(E)	3.05	3.75	1.05	8.90	1.15	0.00
		(4.31)	(1.91)	(0.78)	(0.57)	(1.63)	(0.00)
	(L)	0.90	3.55	0.95	11.35	1.20	0.00
		(1.27)	(2.76)	(1.34)	(0.78)	(1.70)	(0.00)

Table A.50. Mean number of each coding category of Interpersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patterns (E)	0.020 (0.027)	0.038 (0.050)
(L)	0.007 (0.016)	0.043 (0.044)
Vicious Cycle (E)	0.000 (0.000)	0.000 (0.000)
(L)	0.000 (0.000)	0.000 (0.000)
Consequences (E)	0.025 (0.026)	0.065 (0.084)
(L)	0.016 (0.008)	0.083 (0.076)
Dir. of con.:pt. to oth. (E)	0.000 (0.000)	0.025 (0.044)
(L)	0.003 (0.005)	0.029 (0.044)
Dir. of con.:oth. to pt. (E)	0.025 (0.026)	0.041 (0.048)
(L)	0.014 (0.009)	0.048 (0.046)
Compares/Contrasts (E)	0.017 (0.020)	0.001 (0.002)
(L)	0.016 (0.015)	0.009 (0.013)
General Interaction (E)	0.026 (0.025)	0.023 (0.036)
(L)	0.018 (0.020)	0.046 (0.054)

Table A.51. Mean number of each coding category of Interpersonal Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category						
Patterns (E)	0.003	0.042	0.016	0.046	0.012	0.055
	(0.004)	(0.041)	(0.023)	(0.065)	(0.016)	(0.078)
(L)	0.000	0.020	0.000	0.025	0.048	0.055
	(0.000)	(0.028)	(0.000)	(0.036)	(0.035)	(0.078)
Vicious Cycle (E)	0.000	0.000	0.000	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
(L)	0.000	0.000	0.000	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Consequences (E)	0.017	0.048	0.008	0.040	0.047	0.110
	(0.025)	(0.032)	(0.016)	(0.022)	(0.066)	(0.156)
(L)	0.011	0.023	0.015	0.056	0.083	0.110
	(0.003)	(0.001)	(0.014)	(0.041)	(0.014)	(0.156)
Dir.of con.:pt to oth.(E)	0.000	0.000	0.000	0.019	0.000	0.055
	(0.000)	(0.000)	(0.000)	(0.027)	(0.000)	(0.078)
(L)	0.000	0.006	0.002	0.007	0.024	0.055
	(0.000)	(0.008)	(0.003)	(0.010)	(0.035)	(0.078)
Dir.of con.:oth.to pt.(E)	0.017	0.048	0.008	0.021	0.047	0.055
	(0.025)	(0.032)	(0.016)	(0.004)	(0.066)	(0.078)
(L)	0.011	0.017	0.012	0.031	0.059	0.055
	(0.003)	(0.009)	(0.017)	(0.033)	(0.049)	(0.078)
Compares/Contrasts (E)	0.003	0.026	0.022	0.002	0.000	0.000
	(0.004)	(0.036)	(0.007)	(0.003)	(0.000)	(0.000)
(L)	0.011	0.020	0.017	0.014	0.012	0.000
	(0.003)	(0.028)	(0.017)	(0.019)	(0.017)	(0.000)
General Interaction (E)	0.030	0.037	0.011	0.056	0.012	0.000
	(0.043)	(0.020)	(0.008)	(0.052)	(0.016)	(0.000)
(L)	0.009	0.035	0.010	0.115	0.024	0.000
	(0.013)	(0.028)	(0.014)	(0.007)	(0.001)	(0.000)

Table A.52. The mean rate of therapist references to each coding category of Interpersonal Links of the Coding System of Therapeutic Focus across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour		Cognitive	Psychodynamic		
		Cog.-beh.	Conversational		Psychoanalytic	
Coding Category						
Patterns (E)	0.002	0.012	0.004	0.002	0.006	0.050
	(0.003)	(0.009)	(0.006)	(0.003)	(0.009)	(0.070)
(L)	0.000	0.011	0.000	0.008	0.023	0.038
	(0.000)	(0.015)	(0.000)	(0.001)	(0.015)	(0.054)
Vicious Cycle (E)	0.000	0.000	0.000	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
(L)	0.000	0.000	0.000	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Consequences (E)	(0.018)	(0.006)	(0.003)	(0.011)	(0.035)	(0.140)
(L)	0.007	0.010	0.006	0.019	0.041	0.077
	(0.002)	(0.005)	(0.006)	(0.009)	(0.012)	(0.109)
Dir.of con.:pt.to oth. (E)	0.000	0.000	0.000	0.008	0.000	0.050
	(0.000)	(0.000)	(0.000)	(0.012)	(0.000)	(0.070)
(L)	0.000	0.002	0.001	0.002	0.011	0.038
	(0.000)	(0.002)	(0.001)	(0.003)	(0.016)	(0.054)
Dir.of con.:oth.to pt. (E)	0.013	0.014	0.002	0.009	0.025	0.050
	(0.018)	(0.006)	(0.003)	(0.001)	(0.035)	(0.070)
(L)	0.007	0.008	0.005	0.014	0.030	0.038
	(0.002)	(0.007)	(0.007)	(0.016)	(0.027)	(0.054)
Compares/Contrasts (E)	0.002	0.010	0.006	0.001	0.000	0.000
	(0.003)	(0.014)	(0.003)	(0.001)	(0.000)	(0.000)
(L)	0.007	0.011	0.007	0.006	0.005	0.000
	(0.002)	(0.015)	(0.007)	(0.009)	(0.008)	(0.000)
General Interaction (E)	0.023	0.013	0.003	0.024	0.006	0.000
	(0.032)	(0.010)	(0.002)	(0.024)	(0.009)	(0.000)
(L)	0.006	0.012	0.004	0.043	0.012	0.000
	(0.008)	(0.005)	(0.006)	(0.011)	(0.001)	(0.000)

2.5 The Mean Total of Interpersonal and Intrapersonal References and the Ratio of Interpersonal to Intrapersonal References

The mean total percentage of statements within sessions in which intrapersonal and interpersonal factors were focused on by therapists was analysed across early and late sessions and by type of therapy. The mean total percentage of intrapersonal and interpersonal factors divided by the respective number of coding categories subsumed within each was also calculated across early and late sessions and by type of therapy. These percentages are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.53 and for each of the six therapy groups in Table A.54. These tables also present the analyses in a format of the ratio of intrapersonal to interpersonal factors in groups.

The mean total number of times per therapist statement each category of interpersonal links was focused on by therapists across the two therapy groupings is presented in Table A.55 and across the six therapy groups is presented in Table A.56.

The mean total rate of therapists' focus on each category of interpersonal links was analysed across early and late sessions and the six therapy groups. The mean total rate of intrapersonal and interpersonal factors divided by the respective number of coding categories subsumed within each was also calculated across early and late sessions and by type of therapy. These percentages are presented for the six therapy groups in Table A.57.

The Two Therapy Groupings and the Six Therapy Groups

Two-way repeated measures ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the total percentage of therapist statements within sessions containing interpersonal and intrapersonal factors and the mean total number of these factors. Further two-way repeated measures ANOVAs also compared the six therapy groups with respect to the mean total percentage of therapist statements within sessions containing interpersonal and intrapersonal factors, and the mean total occurrence and rate of these factors. The analyses did not show any significant effect of session order or of the interaction of session order and type of therapy on intrapersonal and interpersonal totals. They did show however significant effects of type of therapy which replicated findings from independent samples t-Tests and from one-way ANOVAs reported above (see page 396).

These significant effects of type of therapy included on the mean total occurrence of intrapersonal factors ($F(5, 6) = 37.526$, $p<0.001$), with further one-way ANOVAs also

Table A.53 Mean total percentage of therapist statements across early and late sessions and the two therapy groupings containing Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus and the Ratio of these factors within groups (standard deviation in brackets)

Group		Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category			
Intrapersonal Total	(E)	14.88 (12.11)	32.71 (23.92)
	(L)	6.16 (4.15)	31.77 (23.46)
Intrapersonal Total/ no of Factor	(E)	3.72 (3.03)	8.18 (5.98)
	(L)	1.54 (1.04)	7.94 (5.87)
Interpersonal Total	(E)	8.80 (5.99)	14.53 (13.19)
	(L)	5.65 (3.50)	18.15 (11.31)
Interpersonal Total/ no of Factors	(E)	1.76 (1.20)	2.91 (2.64)
	(L)	1.13 (0.70)	3.63 (2.26)
Ratio of Intrapersonal to Interpersonal Factors	(E)	1.69 : 1	2.25 : 1
	(L)	1.09 : 1	1.75 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	(E)	2.11 : 1	2.81 : 1
	(L)	1.36 : 1	2.19 : 1

showing an overall significant effect of type of therapy on mean intrapersonal totals across early sessions of therapy ($F(5, 11) = 37.141$, $p<0.001$) and across late sessions of therapy ($F(5, 11) = 14.928$, $p<0.005$). Further analyses of this significant effect of therapy type on early sessions showed a higher intrapersonal total in early sessions of the Psychoanalytic psychotherapy group than in the Behaviour, Cognitive, Conversational and Psychodynamic groups (Scheffe tests, $p<0.001$, $p<0.005$, $p<0.001$ and $p<0.001$ respectively). Further analyses of the significant effect of therapy type on late sessions showed the Psychoanalytic group to have higher intrapersonal totals in late sessions than did the Behaviour and Cognitive therapy groups (Scheffe tests, $p<0.001$ and $p<0.01$ respectively).

Table A.54 Mean total percentage of therapist statements across early and late sessions and the six therapy groups containing Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus and the Ratio of these factors within groups (standard deviation in brackets)

Group		Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category							
Intrapersonal Total	(E)	2.20	28.65	13.80	24.20	12.85	61.10
		(0.57)	(4.31)	(3.39)	(15.84)	(1.63)	(7.92)
	(L)	2.55	10.45	5.50	14.55	28.95	51.80
		(3.61)	(0.78)	(2.97)	(12.94)	(9.83)	(32.81)
Intrapersonal Total/ no of Factors	(E)	0.55	7.16	3.45	6.05	3.21	15.27
		(0.14)	(1.08)	(0.85)	(3.96)	(0.41)	(1.98)
	(L)	0.64	2.61	1.38	3.64	7.24	12.95
		(0.90)	(0.19)	(0.74)	(3.24)	(2.46)	(8.20)
Interpersonal Total	(E)	5.40	15.35	5.65	20.00	6.95	16.65
		(5.94)	(1.77)	(3.46)	(5.94)	(9.83)	(23.55)
	(L)	3.10	9.75	4.10	20.85	26.45	7.15
		(0.71)	(2.90)	(0.99)	(6.58)	(9.97)	(10.11)
Interpersonal Total/ no of Factors	(E)	1.08	3.07	1.13	4.00	1.39	3.33
		(1.19)	(0.35)	(0.69)	(1.19)	(1.97)	(4.71)
	(L)	0.62	1.95	0.82	4.17	5.29	1.43
		(0.14)	(0.58)	(0.20)	(1.32)	(1.99)	(2.02)
Ratio of Intrapersonal to Interpersonal Factors	(E)	0.41 : 1	1.87 : 1	2.44 : 1	1.21 : 1	1.25 : 1	3.67 : 1
	(L)	0.82 : 1	1.07 : 1	1.34 : 1	0.70 : 1	1.09 : 1	7.24 : 1
Ratio of Intrapersonal /no of Factors to Interpersonal/no of Factors	(E)	0.51 : 1	2.33 : 1	3.05 : 1	1.51 : 1	1.57 : 1	4.59 : 1
	(L)	1.03 : 1	1.34 : 1	1.68 : 1	0.87 : 1	1.37 : 1	9.06 : 1

Table A.55 Mean total number of Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus in therapist statements and the Ratio of these factors within groups across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group		Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category			
Intrapersonal Total	(E)	0.155 (0.124)	0.273 (0.267)
	(L)	0.062 (0.042)	0.325 (0.267)
Intrapersonal Total/ no of Factors	(E)	0.039 (0.031)	0.068 (0.067)
	(L)	0.015 (0.010)	0.081 (0.067)
Interpersonal Total	(E)	0.088 (0.059)	0.126 (0.136)
	(L)	0.057 (0.035)	0.181 (0.112)
Interpersonal Total/ no of Factors	(E)	0.018 (0.012)	0.025 (0.027)
	(L)	0.011 (0.007)	0.036 (0.022)
Ratio of Intrapersonal to Interpersonal Factors	(E)	1.76 : 1	2.17 : 1
	(L)	1.09 : 1	1.80 : 1
Ratio of Intrapersonal/ no of Factors to Interpersonal/no of Factors	(E)	2.16 : 1	2.72 : 1
	(L)	1.36 : 1	2.25 : 1

Table A.56 Mean total number of Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus in therapist statements and the Ratio of these factors within groups across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour		Cognitive	Psychodynamic		
			Cog.-beh.		Conversational		Psychoanalytic
Coding Category							
Intrapersonal Total	(E)	0.022	0.293	0.149	0.082	0.129	0.610
		(0.006)	(0.045)	(0.026)	(0.068)	(0.016)	(0.085)
	(L)	0.025	0.105	0.055	0.147	0.179	0.650
		(0.036)	(0.008)	(0.030)	(0.132)	(0.055)	(0.141)
Intrapersonal Total/ no of Factors	(E)	0.005	0.073	0.037	0.020	0.032	0.153
		(0.001)	(0.011)	(0.006)	(0.017)	(0.004)	(0.021)
	(L)	0.006	0.026	0.014	0.037	0.045	0.163
		(0.009)	(0.002)	(0.008)	(0.033)	(0.014)	(0.035)
Interpersonal Total	(E)	0.054	0.153	0.057	0.145	0.070	0.165
		(0.059)	(0.017)	(0.035)	(0.136)	(0.099)	(0.233)
	(L)	0.031	0.098	0.041	0.210	0.167	0.165
		(0.077)	(0.029)	(0.010)	(0.065)	(0.039)	(0.233)
Interpersonal Total/ no of Factors	(E)	0.011	0.031	0.011	0.029	0.014	0.033
		(0.012)	(0.003)	(0.007)	(0.027)	(0.020)	(0.047)
	(L)	0.006	0.020	0.008	0.042	0.033	0.033
		(0.002)	(0.006)	(0.002)	(0.013)	(0.008)	(0.047)
Ratio of Intrapersonal to Interpersonal Factors	(E)	0.41 : 1	1.92 : 1	2.61 : 1	0.57 : 1	1.84 : 1	3.70 : 1
	(L)	0.81 : 1	1.07 : 1	1.34 : 1	0.70 : 1	1.07 : 1	3.94 : 1
Ratio of Intrapersonal /no of Factors to Interpersonal/no of Factors	(E)	0.45 : 1	2.35 : 1	3.36 : 1	0.69 : 1	2.29 : 1	4.64 : 1
	(L)	1.00 : 1	1.30 : 1	1.75 : 1	0.88 : 1	1.36 : 1	4.94 : 1

Table A.57 Mean Rate of Intrapersonal and Interpersonal Factors of the Coding System of Therapeutic Focus in therapist statements and the Ratio of these factors within groups across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category							
Intrapersonal Total	(E)	0.017	0.093	0.042	0.036	0.072	0.500
		(0.003)	(0.014)	(0.014)	(0.032)	(0.004)	(0.006)
	(L)	0.015	0.045	0.022	0.048	0.086	0.492
		(0.022)	(0.023)	(0.012)	(0.033)	(0.017)	(0.152)
Intrapersonal Total/ no of Factors	(E)	0.004	0.023	0.010	0.009	0.018	0.125
		(0.001)	(0.003)	(0.003)	(0.008)	(0.001)	(0.001)
	(L)	0.004	0.011	0.006	0.012	0.021	0.123
		(0.005)	(0.006)	(0.003)	(0.008)	(0.004)	(0.038)
Interpersonal Total	(E)	0.041	0.049	0.015	0.063	0.037	0.149
		(0.044)	(0.010)	(0.007)	(0.064)	(0.053)	(0.210)
	(L)	0.020	0.044	0.017	0.076	0.081	0.115
		(0.004)	(0.030)	(0.005)	(0.000)	(0.010)	(0.163)
Interpersonal Total/ no of Factors	(E)	0.008	0.010	0.003	0.013	0.007	0.030
		(0.009)	(0.002)	(0.001)	(0.013)	(0.011)	(0.042)
	(L)	0.004	0.009	0.003	0.015	0.016	0.023
		(0.001)	(0.006)	(0.001)	(0.000)	(0.002)	(0.033)
Ratio of Intrapersonal to Interpersonal Factors	(E)	0.41 : 1	1.90 : 1	2.80 : 1	0.57 : 1	1.95 : 1	3.36 : 1
	(L)	0.75 : 1	1.02 : 1	1.29 : 1	0.63 : 1	1.06 : 1	4.28 : 1
Ratio of Intrapersonal /no of Factors to Interpersonal/no of Factors	(E)	0.50 : 1	2.30 : 1	3.33 : 1	0.69 : 1	2.57 : 1	4.17 : 1
	(L)	1.00 : 1	1.22 : 1	2.00 : 1	0.80 : 1	1.31 : 1	5.35 : 1

2.6 Who Therapists Focus On

The percentage of statements within sessions in which each person category was focused on by therapists was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.58. Percentages are also presented for each of the six therapy groups in Table A.59.

The mean number of times per therapist statement each person category was focused on by therapists across early and late sessions and the two therapy groupings is presented in Table A.60 and across the six therapy groups is presented in Table A.61.

The rate of therapists' focus on each person category across early and late sessions and the six therapy groups in Table A.62.

Table A.58. Percentage of therapist statements across early and late sessions and the two therapy groupings containing each coding category of Persons Involved of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group / Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Patient (E)	73.48 (21.00)	67.92 (35.09)
(L)	77.88 (11.29)	82.52 (12.15)
Therapist (E)	7.73 (4.08)	9.25 (12.21)
(L)	7.90 (4.83)	20.43 (6.10)
Parent (E)	2.15 (2.23)	21.48 (14.92)
(L)	0.55 (0.73)	20.93 (17.78)
Mate (E)	5.95 (10.76)	15.43 (23.60)
(L)	4.75 (5.75)	5.83 (6.11)
Child (E)	2.23 (4.61)	2.78 (6.82)
(L)	2.67 (4.13)	5.33 (9.04)
Dream/Fantasy Figure (E)	0.00 (0.00)	1.65 (2.87)
(L)	0.00 (0.00)	0.43 (1.06)
Acquaintance/Strangers (E)	14.37 (12.22)	10.52 (11.48)
and Others in General (L)	16.03 (8.58)	9.48 (10.97)

The Two Therapy Groupings

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements within sessions containing references to each persons involved category and the mean occurrence of such references. These analyses did not show any significant effect of session order or of the interaction of session order and type of therapy on person categories. There were, however, significant effects of type of therapy which replicated findings from independent samples t-Tests reported above (see page 398). In addition, a paired samples t-Test showed the Psychodynamic grouping of therapies to contain a higher mean occurrence of references to the therapist in late sessions than in early ($t(5) = 2.287$, $p<0.05$).

The Six Therapy Groups

A two-way repeated measure ANOVA with one within-subjects factor (session order) and with one between-subjects factor (type of therapy) compared the six therapy groups with respect to the percentage of therapist statements within sessions containing references to each of the persons involved categories, and the mean occurrence and rate of these references. The analyses showed a significant reduction in late sessions over early of the percentage of statements containing references to the mate coding category ($F(1, 6) = 15.690) = p<0.01$) and that this interacted significantly with type of therapy ($F(5, 6) = 24.682$, $p<0.001$). Further analyses of this showed:

i) a significant difference in the effect of the interaction of session order and type of therapy between the Psychoanalytic psychotherapy group and the Behaviour therapy group ($F(1, 2) = 57.763$, $p<0.05$) and also a significant difference between the groups on the effect of session order ($F(1, 2) = 39.216$, $p<0.05$). The Psychoanalytic group had a higher percentage of statements containing such references in both early and late sessions than did the Behaviour

therapy group with the references decreasing in late over early sessions of the Psychoanalytic group whereas they increased in the Behaviour therapy group.

ii) a significant difference in the effect of the interaction of session order and type of therapy between the Psychoanalytic psychotherapy group and the Cognitive-behaviour therapy group ($F(1, 2) = 29.565$, $p<0.05$) and also a significant difference between the groups on the effect of session order ($F(1, 2) = 73.929$, $p<0.05$). The Psychoanalytic group had a higher percentage of statements containing such references in early sessions which then significantly decreased in late sessions to a level lower than in the Cognitive-behaviour group whose references also decreased.

Table A.59. Percentage of therapist statements across early and late sessions and the six therapy groups containing each coding category of Persons Involved of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group		Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category							
Patient	(E)	52.95	92.40	75.10	93.25	77.15	33.35
		(20.86)	(7.35)	(12.30)	(0.92)	(9.26)	(47.16)
	(L)	66.15	90.40	77.10	92.55	74.65	80.35
		(5.44)	(3.54)	(2.26)	(0.92)	(18.60)	(7.57)
Therapist	(E)	10.10	5.45	7.65	5.50	5.55	16.65
		(3.96)	(4.03)	(5.44)	(2.47)	(4.60)	(23.55)
	(L)	13.85	6.45	3.40	20.30	21.35	19.65
		(0.64)	(0.21)	(0.71)	(9.48)	(6.01)	(7.57)
Parent	(E)	1.65	2.35	2.45	7.70	34.55	22.20
		(1.06)	(3.32)	(3.46)	(7.50)	(9.40)	(15.70)
	(L)	0.90	0.00	0.75	4.25	26.40	32.15
		(1.27)	(0.00)	(0.35)	(6.01)	(6.22)	(25.24)
Mate	(E)	0.30	17.55	0.00	1.85	0.00	44.45
		(0.42)	(13.22)	(0.00)	(2.62)	(0.00)	(15.77)
	(L)	3.90	9.15	1.20	1.70	8.65	7.15
		(5.52)	(8.27)	(0.99)	(2.40)	(5.02)	(10.11)
Child	(E)	0.30	6.40	0.00	8.35	0.00	0.00
		(0.42)	(7.35)	(0.00)	(11.81)	(0.00)	(0.00)
	(L)	0.00	5.10	2.90	16.00	0.00	0.00
		(0.00)	(7.21)	(2.69)	(8.20)	(0.00)	(0.00)
Dream/ Fantasy	(E)	0.00	0.00	0.00	0.00	4.95	0.00
Figure		(0.00)	(0.00)	(0.00)	(0.00)	(2.90)	(0.00)
	(L)	0.00	0.00	0.00	0.00	1.30	0.00
		(0.00)	(0.00)	(0.00)	(0.00)	(1.84)	(0.00)
Acquaintance,	(E)	15.05	7.65	20.30	13.50	18.05	0.00
Strangers, Others		(10.68)	(10.82)	(18.81)	(3.39)	(17.18)	(0.00)
in general	(L)	14.95	16.25	16.90	11.70	2.45	14.30
		(0.92)	(9.69)	(16.40)	(5.09)	(3.46)	(20.22)

iii) a significant difference in the effect of the interaction of session order and type of therapy between the Psychoanalytic psychotherapy group and Cognitive therapy group ($F(1, 2) = 89.888$, $p<0.01$) and also a significant difference between the groups on the effect of session order ($F(1, 2) = 79.030$, $p<0.05$). The Psychoanalytic group had a higher percentage of statements containing such references in both early and late sessions. These references then reduced whereas in the Cognitive therapy group they increased.

iv) a significant difference in the effect of the interaction of session order and type of therapy between the Psychoanalytic psychotherapy group and Conversational psychotherapy group ($F(1, 2) = 49.252$, $p<0.05$) and also a significant difference between the groups on the effect of session order ($F(1, 2) = 49.034$, $p<0.05$). The Psychoanalytic group had a higher percentage of statements containing such references in both early and late sessions. The references reduced in late over early sessions of both groups.

v) a significant difference in the effect of the interaction of session order and type of therapy between the Psychoanalytic psychotherapy group and Psychodynamic psychotherapy group ($F(1, 2) = 73.819$, $p<0.05$) and also a significant difference between the groups on the effect of session order ($F(1, 2) = 28.698$, $p<0.05$). The Psychoanalytic group had a higher percentage of statements containing such references in early sessions which then significantly decreased in late sessions to a level lower than in the Psychodynamic psychotherapy group whose references increased in late sessions.

Table A.60. Mean total of each coding category of Persons Involved of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Patient (E)	0.735 (0.212)	0.823 (0.127)
(L)	0.778 (0.114)	0.887 (0.086)
Therapist (E)	0.078 (0.041)	0.112 (0.126)
(L)	0.078 (0.047)	0.197 (0.110)
Parent (E)	0.021 (0.022)	0.212 (0.152)
(L)	0.005 (0.007)	0.199 (0.178)
Mate (E)	0.060 (0.108)	0.158 (0.235)
(L)	0.048 (0.057)	0.119 (0.221)
Child (E)	0.041 (0.093)	0.036 (0.068)
(L)	0.026 (0.041)	0.053 (0.091)
Dream/Fantasy Figure (E)	0.000 (0.000)	0.017 (0.029)
(L)	0.000 (0.000)	0.012 (0.028)
Acquaintance/Strangers (E)	0.144 (0.124)	0.126 (0.137)
and Others in General (L)	0.161 (0.087)	0.097 (0.114)

The analyses also showed a significant decrease in the percentage of statements containing references to dream or fantasy figures ($F(1, 6) = 23.684$, $p<0.005$) with this interacting significantly with type of therapy ($F(5, 6) = 23.684$, $p<0.001$). Further analyses of this interaction showed a significant difference between the Psychodynamic psychotherapy group, in which the percentage of statements containing such references decreased in late over early

sessions, and the Behaviour, Cognitive-behaviour, Cognitive, Conversational and Psychoanalytic groups (all with $F = (1, 2) = 23.684$, $p<0.05$) none of whom made any references in either early or late sessions.

There were significant effects of type of therapy which replicated findings from independent samples t-Tests reported above (see page 399) but no other analyses of session order or the interaction of session order and type of showed any significant effect across the two therapy groupings or the six therapy groups.

Table A.61. Mean total of each coding category of Persons Involved of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category							
Patient	(E)	0.530	0.925	0.750	0.860	0.775	0.835
		(0.212)	(0.078)	(0.127)	(0.099)	(0.092)	(0.233)
	(L)	0.660	0.905	0.770	0.925	0.860	0.875
		(0.057)	(0.035)	(0.028)	(0.007)	(0.028)	(0.177)
Therapist	(E)	0.101	0.060	0.074	0.114	0.056	0.165
		(0.041)	(0.048)	(0.051)	(0.107)	(0.046)	(0.233)
	(L)	0.135	0.064	0.034	0.021	0.097	0.290
		(0.007)	(0.002)	(0.071)	(0.092)	(0.104)	(0.057)
Parent	(E)	0.016	0.024	0.025	0.070	0.345	0.220
		(0.010)	(0.033)	(0.035)	(0.085)	(0.092)	(0.156)
	(L)	0.009	0.000	0.007	0.042	0.250	0.305
		(0.013)	(0.000)	(0.003)	(0.060)	(0.042)	(0.276)
Mate	(E)	0.003	0.176	0.000	0.028	0.000	0.445
		(0.004)	(0.133)	(0.000)	(0.013)	(0.000)	(0.163)
	(L)	0.039	0.092	0.012	0.017	0.060	0.280
		(0.055)	(0.083)	(0.010)	(0.024)	(0.085)	(0.396)
Child	(E)	0.003	0.121	0.000	0.109	0.000	0.000
		(0.004)	(0.154)	(0.000)	(0.086)	(0.000)	(0.000)
	(L)	0.000	0.050	0.029	0.160	0.000	0.000
		(0.000)	(0.071)	(0.027)	(0.085)	(0.000)	(0.000)
Dream/ Fantasy Figure	(E)	0.000	0.000	0.000	0.000	0.050	0.000
		(0.000)	(0.000)	(0.000)	(0.000)	(0.029)	(0.000)
	(L)	0.000	0.000	0.000	0.000	0.035	0.000
		(0.000)	(0.000)	(0.000)	(0.000)	(0.049)	(0.000)
Acquaintance, Strangers, Others in general	(E)	0.153	0.075	0.205	0.200	0.179	0.000
		(0.108)	(0.106)	(0.191)	(0.127)	(0.171)	(0.000)
	(L)	0.150	0.162	0.171	0.116	0.174	0.000
		(0.014)	(0.096)	(0.168)	(0.049)	(0.178)	(0.000)

Table A.62 The mean rate of therapist references to each coding category of Persons Involved of the Coding System of Therapeutic Focus across early and late sessions and the six therapy groups (standard deviation in brackets)

Group		Behaviour	Cognitive		Psychodynamic		
			Cog.-beh.		Conversational		Psychoanalytic
Coding Category							
Patient	(E)	0.411	0.296	0.211	0.357	0.431	0.702
		(0.137)	(0.065)	(0.068)	(0.088)	(0.022)	(0.281)
	(L)	0.416	0.384	0.313	0.351	0.419	0.650
		(0.012)	(0.184)	(0.023)	(0.105)	(0.032)	(0.070)
Therapist	(E)	0.081	0.017	0.019	0.050	0.032	0.149
		(0.038)	(0.010)	(0.011)	(0.050)	(0.028)	(0.210)
	(L)	0.085	0.027	0.014	0.083	0.044	0.215
		(0.009)	(0.011)	(0.003)	(0.059)	(0.045)	(0.022)
Parent	(E)	0.013	0.006	0.006	0.031	0.194	0.174
		(0.009)	(0.008)	(0.009)	(0.039)	(0.064)	(0.105)
	(L)	0.006	0.000	0.003	0.013	0.123	0.238
		(0.008)	(0.000)	(0.002)	(0.018)	(0.034)	(0.228)
Mate	(E)	0.00	0.064	0.000	0.012	0.000	0.376
		(0.003)	(0.060)	(0.000)	(0.007)	(0.000)	(0.181)
	(L)	0.026	0.046	0.005	0.005	0.027	0.196
		(0.036)	(0.052)	(0.004)	(0.007)	(0.038)	(0.277)
Child	(E)	0.002	0.047	0.000	0.047	0.000	0.000
		(0.003)	(0.062)	(0.000)	(0.041)	(0.000)	(0.000)
	(L)	0.000	0.028	0.012	0.066	0.000	0.000
		(0.000)	(0.039)	(0.012)	(0.051)	(0.000)	(0.000)
Dream/ Fantasy Figure	(E)	0.000	0.000	0.000	0.000	0.027	0.000
		(0.000)	(0.000)	(0.000)	(0.000)	(0.014)	(0.000)
	(L)	0.000	0.000	0.000	0.000	0.018	0.000
		(0.000)	(0.000)	(0.000)	(0.000)	(0.026)	(0.000)
Acquaintance, Strangers, Others in general	(E)	0.117	0.019	0.053	0.079	0.097	0.000
		(0.077)	(0.027)	(0.044)	(0.041)	(0.089)	(0.000)
	(L)	0.095	0.059	0.071	0.041	0.090	0.000
		(0.014)	(0.010)	(0.071)	(0.005)	(0.096)	(0.000)

2.7 The Time Frame of Therapists' Interventions

The percentage of therapist statements within sessions in which each of the potential time frames was coded was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.63. Percentages are also presented for each of the six therapy groups in Table A.64.

The mean number of times per therapist statement each time frame was coded across early and late sessions and the two therapy groupings is presented in Table A.65 and across the six therapy groups is presented in Table A.66.

The rate of coding of each time frame across early and late sessions and the six therapy groups is presented in Table A.67.

Table A.63. Percentage of therapist statements across early and late sessions and the two therapy groupings focusing on each of the Time Frames of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group / Coding Category	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Pre-Adult Past (E)	1.66 (3.28)	15.91 (22.97)
(L)	0.00 (0.00)	6.40 (11.56)
Adult Past (E)	9.55 (16.53)	17.18 (21.42)
(L)	2.95 (2.75)	6.83 (9.94)
Current (E)	27.23 (12.00)	23.32 (18.80)
(L)	30.10 (11.60)	33.88 (9.17)
In Session (E)	9.55 (6.01)	43.23 (24.63)
(L)	6.97 (4.74)	30.27 (14.77)
Future (E)	11.93 (10.05)	1.60 (2.48)
(L)	20.95 (8.80)	11.18 (12.96)
General (E)	25.68 (16.60)	26.63 (25.01)
(L)	26.38 (16.89)	40.38 (7.73)
Irrelevant/Unspecified (E)	20.98 (19.87)	3.47 (4.44)
(L)	17.75 (13.55)	3.85 (5.06)

The Two Therapy Groupings

A two-way repeated measures ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the grouped Psychodynamic psychotherapies and the grouped Cognitive-behaviour therapies with respect to the percentage of therapist statements within sessions coded with each time frame and the mean occurrence of each time frame. These analyses showed a significant increase in late sessions over early of percentage and mean measures of therapist focus on the future time frame ($F(1, 10) = 8.379$, $p<0.05$ and $F(1, 10) = 5.946$, $p<0.05$ respectively). They also showed significant effects of therapy grouping which replicated those reported above from independent samples t-Tests (see page 399).

The Six Therapy Groups

Two-way repeated measure ANOVA with one within-subjects factor (session order) and with one between-subjects factor (type of therapy) compared the six therapy groups with respect to the percentage of therapist statements within sessions coded with each time frame, and the mean occurrence and rate of such references. The analyses showed significant increases in the percentage, mean and rate of therapist focus on the future time frame in late sessions over early ($F(1, 6) = 14.182$, $p<0.01$; $F(1, 6) = 6.568$, $p<0.05$; and $F(1, 6) = 8.574$, $p<0.05$ respectively). There were also significant effects of type of therapy on in session and on irrelevant or unspecified time frames which replicated findings from one-way ANOVAs reported above (see pages 401-402).

There were no other effects of session order across the two therapy groupings and the six therapy groups, and no effects of the interaction of session order and type.

Table A.64. Percentage of therapist statements across early and late sessions and the six therapy groups focusing on each of the Time Frames of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group		Behaviour	Cog.-beh.	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category							
Pre-Adult Past	(E)	0.90	0.00	4.10	8.95	33.25	5.55
		(1.27)	(0.00)	(5.80)	(5.73)	(40.38)	(7.85)
	(L)	0.00	0.00	0.00	0.00	4.90	14.30
		(0.00)	(0.00)	(0.00)	(0.00)	(6.93)	(20.22)
Adult Past	(E)	24.75	3.10	0.80	9.80	13.95	27.80
		(25.81)	(0.99)	(1.13)	(1.84)	(19.73)	(39.32)
	(L)	0.90	1.95	6.00	4.05	16.45	0.00
		(0.57)	(2.76)	(0.99)	(5.73)	(12.94)	(0.00)
Current	(E)	13.70	31.30	36.70	19.05	6.45	44.45
		(10.18)	(0.71)	(6.08)	(4.45)	(0.78)	(15.77)
	(L)	24.20	26.80	39.30	39.10	28.60	33.95
		(12.16)	(2.12)	(16.12)	(9.47)	(7.78)	(12.66)
In Session	(E)	11.35	3.05	14.25	32.80	24.65	72.25
		(4.55)	(0.64)	(5.02)	(12.30)	(15.06)	(7.85)
	(L)	10.25	1.50	9.15	18.60	31.15	41.05
		(2.05)	(0.99)	(4.03)	(7.21)	(4.17)	(22.70)
Future	(E)	4.80	22.35	8.65	2.45	2.35	0.00
		(0.14)	(11.67)	(5.30)	(3.46)	(3.32)	(0.00)
	(L)	24.50	25.10	13.25	23.50	10.05	0.00
		(2.12)	(14.28)	(0.35)	(16.40)	(3.89)	(0.00)
General	(E)	11.30	43.75	22.00	43.85	27.05	0.00
		(11.46)	(7.00)	(10.18)	(1.77)	(34.15)	(0.00)
	(L)	9.35	44.75	25.05	32.15	42.55	46.45
		(1.48)	(5.73)	(11.53)	(7.28)	(1.48)	(5.02)
Irrelevant/	(E)	40.70	4.45	17.80	2.15	8.25	0.00
Unspecified		(23.90)	(4.60)	(6.08)	(0.35)	(5.02)	(0.00)
	(L)	34.35	4.95	13.95	2.70	8.85	0.00
		(2.90)	(0.78)	(1.34)	(3.82)	(5.59)	(0.00)

Table A.65. Mean total of each coding category of Time Frames of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Pre-Adult Past (E)	0.017 (0.033)	0.151 (0.236)
(L)	0.000 (0.000)	0.042 (0.051)
Adult Past (E)	0.095 (0.165)	0.167 (0.219)
(L)	0.030 (0.028)	0.166 (0.219)
Current (E)	0.272 (0.120)	0.291 (0.214)
(L)	0.308 (0.120)	0.333 (0.170)
In Session (E)	0.097 (0.062)	0.374 (0.291)
(L)	0.070 (0.048)	0.315 (0.240)
Future (E)	0.119 (0.102)	0.029 (0.053)
(L)	0.217 (0.081)	0.098 (0.132)
General (E)	0.257 (0.167)	0.190 (0.227)
(L)	0.270 (0.174)	0.343 (0.190)
Irrelevant/Unspecified (E)	0.211 (0.200)	0.053 (0.059)
(L)	0.177 (0.134)	0.025 (0.027)

Table A.66. Mean total of each coding category of Time Frames of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Pre-Adult Past (E)	0.009	0.000	0.041	0.065	0.333	0.055
	(0.012)	(0.000)	(0.058)	(0.092)	(0.406)	(0.078)
(L)	0.000	0.000	0.000	0.000	0.072	0.055
	(0.000)	(0.000)	(0.000)	(0.000)	(0.036)	(0.078)
Adult Past (E)	0.247	0.031	0.008	0.082	0.140	0.280
	(0.258)	(0.011)	(0.011)	(0.040)	(0.198)	(0.396)
(L)	0.009	0.020	0.060	0.041	0.177	0.280
	(0.006)	(0.028)	(0.010)	(0.057)	(0.146)	(0.396)
Current (E)	0.137	0.315	0.365	0.365	0.064	0.445
	(0.103)	(0.007)	(0.064)	(0.205)	(0.008)	(0.163)
(L)	0.265	0.265	0.395	0.390	0.205	0.405
	(0.148)	(0.021)	(0.163)	(0.099)	(0.91)	(0.219)
In Session (E)	0.116	0.030	0.145	0.151	0.245	0.725
	(0.048)	(0.007)	(0.049)	(0.125)	(0.148)	(0.078)
(L)	0.104	0.015	0.091	0.190	0.240	0.515
	(0.023)	(0.010)	(0.040)	(0.071)	(0.141)	(0.375)
Future (E)	0.048	0.225	0.085	0.065	0.023	0.000
	(0.002)	(0.120)	(0.050)	(0.092)	(0.033)	(0.000)
(L)	0.245	0.250	0.155	0.235	0.060	0.000
	(0.021)	(0.141)	(0.035)	(0.163)	(0.019)	(0.000)
General (E)	0.111	0.440	0.220	0.300	0.270	0.000
	(0.112)	(0.071)	(0.099)	(0.184)	(0.340)	(0.000)
(L)	0.091	0.450	0.270	0.320	0.460	0.250
	(0.012)	(0.057)	(0.141)	(0.071)	(0.071)	(0.354)
Irrelevant/ (E)	0.410	0.044	0.180	0.074	0.083	0.000
Unspecified	(0.240)	(0.046)	(0.057)	(0.079)	(0.052)	(0.000)
(L)	0.340	0.050	0.140	0.027	0.048	0.000
	(0.028)	(0.008)	(0.014)	(0.038)	(0.002)	(0.000)

Table A.67. Mean rate of each coding category of Time Frames of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Pre-Adult Past (E)	0.007	0.000	0.010	0.029	0.194	0.050
	(0.010)	(0.000)	(0.014)	(0.041)	(0.239)	(0.070)
(L)	0.000	0.000	0.000	0.000	0.034	0.038
	(0.000)	(0.000)	(0.000)	(0.000)	(0.014)	(0.054)
Adult Past (E)	0.187	0.011	0.002	0.035	0.074	0.252
	(0.189)	(0.006)	(0.004)	(0.021)	(0.105)	(0.357)
(L)	0.006	0.011	0.024	0.019	0.090	0.196
	(0.004)	(0.015)	(0.003)	(0.027)	(0.081)	(0.277)
Current (E)	0.105	0.102	0.100	0.145	0.036	0.376
	(0.073)	(0.029)	(0.002)	(0.064)	(0.002)	(0.181)
(L)	0.165	0.113	0.162	0.143	0.095	0.296
	(0.084)	(0.058)	(0.072)	(0.008)	(0.082)	(0.135)
In Session (E)	0.090	0.010	0.041	0.066	0.140	0.603
	(0.031)	(0.001)	(0.020)	(0.060)	(0.092)	(0.141)
(L)	0.066	0.005	0.037	0.068	0.113	0.373
	(0.018)	(0.001)	(0.015)	(0.005)	(0.056)	(0.244)
Future (E)	0.038	0.067	0.025	0.024	0.012	0.000
	(0.001)	(0.017)	(0.018)	(0.034)	(0.017)	(0.000)
(L)	0.155	0.092	0.063	0.099	0.029	0.000
	(0.022)	(0.013)	(0.012)	(0.089)	(0.006)	(0.000)
General (E)	0.090	0.146	0.063	0.129	0.144	0.000
	(0.094)	(0.066)	(0.037)	(0.092)	(0.180)	(0.000)
(L)	0.058	0.194	0.109	0.118	0.227	0.200
	(0.011)	(0.108)	(0.053)	(0.011)	(0.059)	(0.283)
Irrelevant/ (E)	0.329	0.017	0.049	0.028	0.047	0.000
Unspecified	(0.213)	(0.019)	(0.008)	(0.028)	(0.032)	(0.000)
(L)	0.215	0.022	0.057	0.013	0.023	0.000
	(0.030)	(0.013)	(0.004)	(0.018)	(0.002)	(0.000)

2.8 Person Links and Time Links

The percentage of therapist statements within sessions in which links were made between time frames or persons was analysed across early and late sessions and by type of therapy. Mean percentages of each of these coding categories are presented for the two therapy groupings Cognitive-behaviour and Psychodynamic in Table A.68. Percentages are also presented for each of the six therapy groups in Table A.69.

The mean number of times per therapist statement links were made between time frames and between person categories across early and late sessions and the two therapy groupings is presented in Table A.70 and across the six therapy groups is presented in Table A.71.

The mean rate of linking of time frames and of person categories across early and late sessions and the six therapy groups is presented in Table A.72.

Table A.68. Percentage of therapist statements across early and late sessions and the two therapy groupings focusing on Time Links and Person Links of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Time Links (E)	1.03 (0.90)	24.72 (23.03)
(L)	1.17 (1.71)	22.38 (13.14)
Person Links (E)	0.95 (1.95)	7.75 (9.33)
(L)	0.90 (1.04)	18.60 (18.16)

Table A.69. Percentage of therapist statements across early and late sessions and the six therapy groups focusing on Time Links and Person Links of the Coding System of Therapeutic Focus (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Time Links (E)	1.19	0.00	1.20	8.90	15.25	50.00
	(0.14)	(0.00)	(0.57)	(0.57)	(11.67)	(23.62)
(L)	0.00	0.40	3.10	14.20	19.00	33.95
	(0.00)	(0.57)	(1.70)	(10.47)	(13.01)	(12.66)
Person Links (E)	0.15	0.00	2.70	4.00	8.15	11.10
	(0.21)	(0.00)	(3.11)	(2.26)	(11.53)	(15.70)
(L)	0.00	0.80	1.90	3.90	12.60	39.30
	(0.00)	(1.13)	(0.71)	(1.70)	(7.50)	(15.13)

Table A.70. Mean total of Time Links and Person Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the two therapy groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies	Psychodynamic psychotherapies
Coding Category		
Time Links (E)	0.010 (0.009)	0.237 (0.242)
(L)	0.012 (0.017)	0.229 (0.230)
Person Links (E)	0.010 (0.020)	0.075 (0.093)
(L)	0.009 (0.010)	0.172 (0.176)

Table A.71. Mean total of Time Links and Person Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Time Links (E)	0.019	0.000	0.012	0.056	0.155	0.500
	(0.002)	(0.000)	(0.006)	(0.052)	(0.120)	(0.240)
(L)	0.000	0.004	0.031	0.144	0.084	0.460
	(0.000)	(0.006)	(0.017)	(0.108)	(0.020)	(0.297)
Person Links (E)	0.001	0.000	0.027	0.035	0.080	0.110
	(0.002)	(0.000)	(0.031)	(0.029)	(0.113)	(0.156)
(L)	0.000	0.008	0.019	0.039	0.117	0.360
	(0.000)	(0.011)	(0.007)	(0.017)	(0.061)	(0.198)

Table A.72. Mean rate of Time Links and Person Links of the Coding System of Therapeutic Focus contained in therapist statements across early and late sessions and the six therapy groups (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-beh.		Conversational		Psychoanalytic
Coding Category						
Time Links (E)	0.015	0.000	0.004	0.024	0.089	0.426
	(0.001)	(0.000)	(0.002)	(0.024)	(0.073)	(0.251)
(L)	0.000	0.002	0.013	0.061	0.040	0.334
	(0.000)	(0.003)	(0.006)	(0.058)	(0.005)	(0.190)
Person Links (E)	0.001	0.000	0.007	0.015	0.043	0.099
	(0.002)	(0.000)	(0.007)	(0.014)	(0.060)	(0.140)
(L)	0.000	0.004	0.008	0.014	0.059	0.277
	(0.000)	(0.006)	(0.002)	(0.002)	(0.036)	(0.174)

The Two Therapy Groupings and the Six Therapy Groups

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared across early and late sessions and the two therapy groupings the percentage of therapist statements within sessions in which links were made between time frames and between persons and the mean occurrence of these links. A further series of two-way ANOVAs also undertook these analyses across the six therapy groups. The analyses did not find any significant effect of session order or the interaction of session order and type of therapy. They did however find significant effects of type of therapy on time links and person links which replicated the findings of independent samples t-Tests and one-way ANOVAs reported above (see pages 403-404).

APPENDIX X

RESULTS III

Therapists' Response to Patients' Negative Material (Additional Analyses)

1. Patients' Expressed Negative Material

Results are presented of the percentage of statements in sessions containing negative comment about the therapy or therapist, and the mean occurrence of such comments per patient statement.

Results of analyses of the percentage of statements containing negative comments and the mean occurrence of negative comments per patient statement across the two therapy groupings are presented in Table A.73 and across the six therapy groups in Table A.74.

Table A.73. The Percentage of Patient Statements Containing Negative Comments and their Mean Occurrence per Statement Across the Two Therapy Groupings (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Coding category				
Percentage:				
Explicit	3.27	(3.54)	9.39	(9.58)
Implicit	19.34	(10.23)	37.14	(21.72)
Expl.& Impl	22.60	(11.47)	46.53	(20.56)
Mean:				
Explicit	0.03	(0.04)	0.11	(0.12)
Implicit	0.21	(0.12)	0.76	(0.92)
Expl.& Impl	0.24	(0.13)	0.88	(0.89)

1.1 Patients' explicitly expressed material

The Two Therapy Groupings and the Six Therapy Groups

Independent Samples t-Tests were used to compare the Cognitive-behaviour and Psychodynamic grouping of therapies, and one-way ANOVAs to compare the six therapy groups, with respect to the percentage of patient statements in sessions containing explicitly expressed negative material about the therapist or therapy and the mean occurrence per patient statement of such comments. The tests did not show any significant difference between the two groupings or the six therapy groups on these measures.

Table A.74. The Percentage of Patient Statements Containing Negative Comments and their Mean Occurrence per Statement Across the Six Therapy Groupings (standard deviation in brackets)

Group	Behaviour	Cog.-behaviour	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Coding Category						
Percentage:						
Explicit	1.15	1.27	7.38	13.41	9.20	5.56
	(1.99)	(1.85)	(2.18)	(9.98)	(8.49)	(11.11)
Implicit	8.74	27.86	21.40	31.55	20.94	58.93
	(4.10)	(9.85)	(4.20)	(11.60)	(8.15)	(22.45)
Expl.& Impl.	9.89	29.14	28.79	44.96	30.14	64.48
	(3.19)	(11.64)	(3.61)	(18.56)	(12.88)	(15.76)
Mean:						
Explicit	0.01	0.01	0.08	0.18	0.10	0.06
	(0.02)	(0.02)	(0.26)	(0.13)	(0.10)	(0.11)
Implicit	0.09	0.31	0.22	0.48	0.24	1.57
	(0.04)	(0.12)	(0.05)	(0.22)	(0.10)	(1.31)
Expl.& Impl.	0.10	0.32	0.30	0.66	0.34	1.62
	(0.03)	(0.13)	(0.03)	(0.33)	(0.17)	(1.25)

1.2 Patients' implicitly expressed material

The Two Therapy Groupings and the Six Therapy Groups
Independent Samples t-Tests were used to compare the Cognitive-behaviour and Psychodynamic grouping of therapies, and one-way ANOVAs to compare the six therapy groups, with respect to the percentage of patient statements in sessions containing implicitly expressed negative material about the therapist or therapy and the mean occurrence per patient statement of such comments. One-way ANOVAs for the percentage of patient statements in sessions containing these implicit references, and the mean of them found significant effects of type of therapy across the six therapy groups ($F(5, 18) = 8.224$, $p<0.001$ and $F(5, 18) = 3.973$, $p<0.05$ respectively). A priori contrasts, however, did not provide any support for the hypothesis that the Psychodynamic and the Psychoanalytic psychotherapy groups would contain significantly lower levels of implicit negative references than would the Behaviour, Cognitive-behaviour and Cognitive therapy groups. Further analyses though did show the Psychoanalytic psychotherapy group to contain a significantly higher percentage of statements containing such references than the Behaviour therapy group (Scheffe test, $p<0.001$).

No other analyses of patients' implicit negative references showed any significant differences either across the two therapy groupings or the six therapy groups.

1.3 Patients' explicitly and implicitly expressed material

The Two Therapy Groupings
An Independent Samples t-Test was used to compare, across the Cognitive-behaviour and Psychodynamic grouping of therapies, the combined percentage of patient statements in sessions containing explicit and containing implicit negative comments about the therapy or

therapist. The test show the Psychodynamic grouping of therapies to contain a significantly higher combined percentage than the Cognitive-behaviour grouping ($t(22) = 3.520$, $p<0.005$).

The Six Therapy Groups

A one-way ANOVA for the combined percentage of statements in sessions containing explicit and implicit references to negative material about the therapist or therapy, and for their mean occurrence, found significant effects of type of therapy across the six therapy groups ($F(5, 18) = 8.864$, $p<0.001$ and $F(5, 18) = 4.279$, $p<0.001$ respectively). Further analyses showed the Psychoanalytic psychotherapy group to contained higher percentage scores than did the Behaviour therapy group (Scheffe test, $p<0.001$).

No other analyses of patients' combined explicit and implicit negative references showed any significant differences either across the two therapy groupings or the six therapy groups.

1.4 Patients' Expressed Negative Material Across Early and Late Sessions

Results are presented of the occurrence in early and in late sessions of therapy of patient negative comment about the therapy or therapist.

Results of analyses of patients' negative comments across the six therapy groups and early and late sessions are presented in Table A.75. Categorised therapists' responses to them are given in Table A.76. Results of analyses, across early and late sessions, of the percentage of statements containing negative comments and the mean occurrence of negative comments per patient statement, across the two therapy groupings are presented in Table A.77 and across the six therapy groups in Table A.77.

Table A.75. The Number of Patient Statements Containing Negative Comments Across the Six Therapy Groups and Across Early and Late Sessions (standard deviation in brackets)

Group	Behaviour	Cog.-behaviour	Cognitive	Conversational	Psychoanalytic	Psychodynamic
Patient Category						
Patient:						
Explicit (E)	4.50	0.50	12.50	9.00	5.50	1.00
	(3.54)	(0.71)	(3.54)	(7.07)	(6.36)	(1.41)
Explicit (L)	0.00	1.00	9.50	5.50	4.50	0.00
	(0.00)	(1.41)	(0.71)	(6.36)	(4.95)	(0.00)
Implicit (E)	15.50	19.50	32.00	14.50	8.00	2.50
	(9.19)	(6.36)	(12.73)	(3.54)	(4.24)	(0.71)
Implicit (L)	17.50	21.50	38.50	16.00	14.00	4.00
	(10.61)	(0.71)	(27.58)	(5.66)	(0.00)	(2.83)
Expl.& Impl. (E)	20.00	20.00	44.50	23.50	13.50	3.50
	(5.66)	(7.07)	(16.26)	(10.61)	(10.61)	(2.12)
Expl.& Impl. (L)	17.50	22.50	48.00	21.50	18.50	4.00
	(10.61)	(0.71)	(28.28)	(12.02)	(4.95)	(2.83)

Table A.76. The Number of Therapist Statements Containing Each Category of Response to Patient Statements Containing Negative Comments Across the Six Therapy Groups and Across Early and Late Sessions (standard deviation in brackets)

Group	Behaviour	Cog.-behaviour	Cognitive	Conversational	Psychoanalytic	Psychodynamic
Patient Category						
Therapist Facilitative response to:						
Explicit (E)	1.50	0.00	5.00	6.50	4.00	0.50
	(0.71)	(0.00)	(2.83)	(4.95)	(5.66)	(0.71)
Explicit (L)	0.00	0.50	4.00	3.50	4.50	0.00
	(0.00)	(0.71)	(2.83)	(3.54)	(4.95)	(0.00)
Implicit (E)	2.50	8.00	8.50	11.50	6.50	2.00
	(3.54)	(1.41)	(6.36)	(6.36)	(3.54)	(0.00)
Implicit (L)	0.50	4.00	15.00	9.00	11.50	2.50
	(0.71)	(0.00)	(16.97)	(5.66)	(0.71)	(2.12)
Expl.& Impl. (E)	4.00	8.00	13.50	18.00	10.50	2.50
	(2.83)	(1.41)	(9.19)	(11.31)	(9.19)	(0.71)
Expl.& Impl. (L)	0.50	4.50	19.00	12.50	16.00	2.50
	(0.71)	(0.71)	(19.80)	(9.19)	(5.66)	(2.12)
Therapist Restrictive response to:						
Explicit (E)	2.00	0.50	6.00	1.00	0.50	0.00
	(1.41)	(0.71)	(0.00)	(0.00)	(0.71)	(0.00)
Explicit (L)	0.00	0.00	4.00	1.00	0.00	0.00
	(0.00)	(0.00)	(1.41)	(1.41)	(0.00)	(0.00)
Implicit (E)	6.50	8.50	15.50	0.50	0.50	0.00
	(6.36)	(6.36)	(0.71)	(0.71)	(0.71)	(0.00)
Implicit (L)	8.00	10.00	13.00	4.50	1.00	0.00
	(2.83)	(4.24)	(5.66)	(3.54)	(1.41)	(0.00)
Expl.& Impl. (E)	8.50	9.00	21.50	1.50	1.00	0.00
	(4.95)	(7.07)	(0.71)	(0.71)	(1.41)	(0.00)
Expl.& Impl. (L)	8.00	10.00	17.00	5.50	1.00	0.00
	(2.83)	(4.24)	(4.24)	(4.95)	(1.41)	(0.00)
Therapist No Response to:						
Explicit (E)	1.00	0.00	1.50	1.50	1.50	0.50
	(1.41)	(0.00)	(0.71)	(2.12)	(0.71)	(0.71)
Explicit (L)	0.00	0.50	1.50	1.00	0.00	0.00
	(0.00)	(0.71)	(0.71)	(1.41)	(0.00)	(0.00)
Implicit (E)	6.50	3.00	8.00	2.50	0.50	0.50
	(0.71)	(1.41)	(5.66)	(2.12)	(0.71)	(0.71)
Implicit (L)	9.00	7.50	10.50	2.50	1.50	1.50
	(8.49)	(3.54)	(4.95)	(3.54)	(0.71)	(0.71)
Expl.& Impl. (E)	7.50	3.00	9.50	4.00	2.00	1.00
	(2.12)	(1.41)	(6.36)	(0.00)	(0.00)	(1.41)
Expl.& Impl (L)	9.00	8.00	12.00	3.50	1.50	1.50
	(8.49)	(4.24)	(4.24)	(2.12)	(0.71)	(0.71)

Table A.77. The Percentage of Patient Statements Containing Negative Comments and their Mean Occurrence per Statement Across the Two Therapy Groupings and Across Early and Late Sessions (standard deviation in brackets)

Group	Cognitive-behaviour therapies		Psychodynamic psychotherapies	
Patient Category				
Percentage:				
Explicit (E)	3.49	(3.50)	11.64	(9.71)
Explicit (L)	3.05	(3.91)	7.14	(9.76)
Implicit (E)	15.84	(9.20)	29.39	(19.75)
Implicit (L)	22.83	(10.78)	44.89	(22.44)
Expl.& Impl. (E)	19.33	(10.26)	41.03	(19.32)
Expl.& Impl. (L)	25.88	(12.59)	52.03	(22.01)
Mean:				
Explicit (E)	0.04	(0.04)	0.14	(0.11)
Explicit (L)	0.03	(0.04)	0.09	(0.13)
Implicit (E)	0.17	(0.10)	0.79	(1.25)
Implicit (L)	0.24	(0.13)	0.73	(0.56)
Expl.& Impl. (E)	0.21	(0.11)	0.93	(1.19)
Expl.& Impl. (L)	0.27	(0.15)	0.82	(0.55)

The Two Therapy Groupings

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the two therapy groupings with respect to the percentage of patient statements in sessions containing negative material expressed explicitly, implicitly, and explicitly and implicitly combined, and the mean occurrence of such references. These two-way repeated measures ANOVAs did not show a significant effect of session order or of the interaction of session order and type of therapy on any of these variables.

Paired samples t-Tests compared these same variables across early and late sessions of each of the two therapy groupings and found no significant effect of session order.

Independent samples t-Tests compared the same variables across early sessions of the two therapy groupings and across late sessions of the two groupings and found no significant effect of therapy group.

The Six Therapy Groups

A series of two-way repeated measures ANOVA with one within-subjects factor session order and one between-subjects factor type of therapy compared the six therapy groups with respect to the level of explicit references, implicit references, and explicit and implicit references combined to negative material about the therapist or therapy. The analyses considered:

i) the number of patient statements in sessions containing such references
ii) the percentage of statements in sessions containing such references
iii) the mean occurrence per statement of such references
iv) the rate of such references

These two-way repeated measures ANOVAs did not show a significant effect of session order or of the interaction of session order and type of therapy on any of these variables.

Table A.78. The Percentage of Patient Statements Containing Negative Comments and their Mean Occurrence per Statement and per Line of Statement (Rate) Across the Six Therapy Groups and Across Early and Late Sessions (standard deviation in brackets)

Group	Behaviour	Cognitive		Psychodynamic		
		Cog.-behaviour		Conversational		Psychoanalytic
Patient Category						
Patient:						
Explicit (E)	2.29	0.59	7.60	13.56	10.24	11.11
	(2.58)	(0.83)	(0.72)	(8.71)	(11.71)	(15.71)
Explicit (L)	0.00	1.96	7.17	13.26	8.16	0.00
	(0.00)	(2.77)	(3.69)	(14.92)	(8.66)	(0.00)
Implicit (E)	5.23	23.05	19.24	23.08	15.09	50.00
	(0.09)	(7.34)	(4.14)	(1.22)	(7.47)	(23.57)
Implicit (L)	12.25	32.68	23.57	40.03	26.79	67.86
	(1.04)	(12.02)	(4.12)	(10.74)	(2.53)	(25.25)
Expl.& Impl. (E)	7.52	23.63	26.84	36.65	25.33	61.11
	(2.67)	(8.17)	(4.86)	(9.92)	(19.18)	(7.86)
Expl.& Impl. (L)	12.25	34.64	30.74	53.28	34.95	67.86
	(1.04)	(14.79)	(4.35)	(25.66)	(6.13)	(25.25)
Mean:						
Explicit (E)	0.02	0.01	0.08	0.18	0.12	0.11
	(0.03)	(0.01)	(0.01)	(0.08)	(0.14)	(0.16)
Explicit (L)	0.00	0.02	0.08	0.18	0.08	0.00
	(0.00)	(0.03)	(0.04)	(0.22)	(0.09)	(0.00)
Implicit (E)	0.06	0.26	0.19	0.35	0.20	1.83
	(0.01)	(0.08)	(0.04)	(0.06)	(0.14)	(2.12)
Implicit (L)	0.12	0.36	0.24	0.61	0.29	1.30
	(0.01)	(0.15)	(0.05)	(0.29)	(0.10)	(0.63)
Expl.& Impl. (E)	0.08	0.27	0.28	0.53	0.32	1.94
	(0.03)	(0.09)	(0.04)	(0.02)	(0.28)	(1.96)
Expl.& Impl. (L)	0.12	0.38	0.32	0.79	0.37	1.30
	(0.01)	(0.18)	(0.01)	(0.50)	(0.09)	(0.63)
Rate:						
Explicit (E)	0.01	0.01	0.04	0.03	0.02	0.02
	(0.01)	(0.01)	(0.01)	(0.02)	(0.02)	(0.04)
Explicit (L)	0.00	0.01	0.03	0.03	0.02	0.00
	(0.00)	(0.01)	(0.02)	(0.04)	(0.02)	(0.00)
Implicit (E)	0.03	0.06	0.09	0.05	0.03	0.18
	(0.02)	(0.01)	(0.04)	(0.01)	(0.02)	(0.14)
Implicit (L)	0.09	0.09	0.09	0.09	0.06	0.09
	(0.01)	(0.05)	(0.02)	(0.06)	(0.01)	(0.01)
Expl.& Impl. (E)	0.03	0.06	0.09	0.05	0.03	0.18
	(0.02)	(0.01)	(0.04)	(0.01)	(0.02)	(0.14)
Expl.& Impl. (L)	0.09	0.09	0.09	0.09	0.06	0.09
	(0.01)	(0.05)	(0.02)	(0.06)	(0.01)	(0.01)

Paired samples t-Tests compared these same variables across early and late sessions of each of the six therapy groups. These analyses showed a significant effect of session order in the Cognitive therapy group on the percentage of statements containing implicit negative material, with this being significantly higher in late over early sessions ($t(1) = 474.341$, $p<0.001$). The analyses also showed a significant effect of session order in the Behaviour therapy group on the mean occurrence per statement of implicit negative material, with this being significantly higher in late over early sessions ($t(1) = 17.990$, $p<0.05$). There was no other significant effect of session order in any group on the level of explicit references, implicit references or explicit and implicit negative references combined.

A series of one way ANOVAs compared the same variables across early sessions of the six therapy groups and across late sessions of the six therapy groups and found no significant effect of session order.

Significant effects on patient negative material of type of therapy across the two groupings and across the six therapy groups replicated those reported above (see pages 442-443) and in Chapter Seven (see pages 285-288).

2. Therapists' Responses to Patients' Negative Material Across Early and Late Sessions of the Six Therapy Groups

Results are presented of therapists' responses, across early and in late sessions, to patient statements containing negative comment about the therapy or therapist.

Table A.76 details, across the six therapy groups, the mean number of therapist statements in a session which contain each category of potential therapist response to negative patient material.

Table A.79 details, across the six therapy groups, what percentage of patient statements containing explicit negative comments are followed by a therapist response which is facilitative, what percentage are followed by a restrictive response and what percentage are followed by a therapist statement which does not contain a response to the negative comment. The table also contains details of therapist response to patients' implicit negative statements and therapist response to explicit and implicit patient negative material combined.

Two-way repeated measures ANOVAs with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the six therapy groups with respect to therapist response to patients' explicit negative comments, their implicit negative comments, and to their explicit and implicit negative material combined. The analyses showed no significant effect of session order or of the interaction of session order and type of therapy on any category of therapist response. There were however a significant effects of type of therapy which replicated findings from one-way ANOVAs reported in Chapter Seven (see pages 292-297).

Paired samples t-Tests compared therapist response to patients' explicit negative comments, their implicit negative comments, and to their explicit and implicit negative material combined across early and late sessions of each the six therapy groups and found no significant effect of session order.

TABLE A.79. The Percentage of Patient Statements Containing Negative Material That Are Followed by Facilitative, Restrictive and No Response Therapist Categories, Analysed Across the Six Therapy Groups and Early and Late Sessions (standard deviation in brackets)

Group	Behaviour	Cog.-behaviour	Cognitive	Conversational	Psychodynamic	Psychoanalytic
Patient Category						
Facilitative Response to:						
Explicit (E)	39.29	0.00	38.33	73.21	40.00	50.00
	(15.15)	(0.00)	(11.79)	(2.53)	(56.57)	(23.35)
Explicit (L)	0.00	50.00	41.11	80.00	100.00	0.00
	(0.00)	(0.00)	(26.71)	(28.28)	(0.00)	(0.00)
Implicit (E)	11.36	42.08	24.55	76.23	80.91	83.33
	(16.07)	(6.48)	(10.12)	(25.30)	(12.86)	(23.57)
Implicit (L)	5.00	18.61	31.17	53.33	82.14	58.33
	(7.07)	(0.61)	(21.75)	(16.50)	(5.05)	(11.79)
Expl.& Impl. (E)	18.75	41.33	28.46	73.19	73.81	80.00
	(8.84)	(7.54)	(10.25)	(15.11)	(10.11)	(28.28)
Expl.& Impl. (L)	5.00	19.96	33.19	54.74	85.45	58.33
	(7.07)	(2.51)	(21.69)	(12.15)	(7.71)	(11.79)
Restrictive Response to:						
Explicit (E)	46.43	100.00	50.00	16.07	5.00	0.00
	(5.05)	(0.00)	(14.14)	(12.63)	(7.07)	(0.00)
Explicit (L)	0.00	0.00	42.78	10.00	0.00	0.00
	(0.00)	(0.00)	(18.07)	(14.14)	(0.00)	(0.00)
Implicit (E)	36.11	40.42	52.12	4.17	4.55	0.00
	(19.64)	(19.45)	(18.52)	(5.89)	(6.43)	(0.00)
Implicit (L)	50.00	46.21	38.34	25.83	7.14	0.00
	(14.14)	(18.21)	(12.77)	(12.96)	(10.10)	(0.00)
Expl.& Impl. (E)	40.63	41.33	51.46	7.86	4.76	0.00
	(13.26)	(20.74)	(17.22)	(6.56)	(6.73)	(0.00)
Expl.& Impl. (L)	50.00	44.76	39.71	22.69	6.67	0.00
	(14.14)	(20.26)	(14.56)	(10.33)	(9.43)	(0.00)
No Response to:						
Explicit (E)	14.29	0.00	11.67	10.71	60.00	50.00
	(20.10)	(0.00)	(2.36)	(15.15)	(56.57)	(7.80)
Explicit (L)	0.00	50.00	16.11	10.00	0.00	0.00
	(0.00)	(0.00)	(8.98)	(14.14)	(0.00)	(0.00)
Implicit (E)	52.52	17.50	23.33	19.61	10.00	16.67
	(35.71)	(12.96)	(8.40)	(19.41)	(14.14)	(23.57)
Implicit (L)	45.00	35.17	30.49	20.83	10.71	41.67
	(21.21)	(17.60)	(8.98)	(29.46)	(5.05)	(11.79)
Expl.& Impl. (E)	40.63	17.33	20.08	18.95	21.43	20.00
	(22.10)	(13.20)	(6.96)	(8.55)	(16.84)	(28.27)
Expl.& Impl. (L)	45.00	35.28	27.10	22.56	7.88	41.67
	(21.21)	(17.75)	(7.13)	(22.48)	(1.71)	(11.79)

2.1 The Mean Therapist Response Across Early and Late Sessions

The mean point on the *Therapist Response (Facilitative-Restrictive) Rating Scale* of therapists' responses to negative patient material across early and late sessions of therapy was analysed across the six therapy groups. The results of this analysis are shown in Table A.80.

Table A.80. The Mean Rating of Therapists' Responses to Negative Patient Material Analysed Across the Six Therapy Groups and Across Early and Late Sessions (standard deviation in brackets)

Group	Mean	Standard Deviation
Behaviour (E)	-0.385	(0.247)
Behaviour (L)	-1.010	(0.156)
Cognitive-behaviour (E)	-0.085	(0.219)
Cognitive-behaviour (L)	-0.470	(0.240)
Cognitive (E)	-0.530	(0.368)
Cognitive (L)	-0.250	(0.297)
Conversational (E)	1.230	(0.410)
Conversational (L)	0.945	(0.035)
Psychodynamic (E)	1.225	(0.559)
Psychodynamic (L)	1.510	(0.339)
Psychoanalytic (E)	2.050	(0.636)
Psychoanalytic (L)	1.415	(0.120)

A two-way repeated measures ANOVA with one within-subjects factor (session order) and one between-subjects factor (type of therapy) compared the mean therapist response across early and late sessions of the six therapy groups. This analysis showed no significant effect of session order or of the interaction of session order and type of therapy on the mean point of therapists' responses. There was however a significant effect of type of therapy which replicated earlier findings from a one-way ANOVA reported in Chapter Seven (see pages 297-298).

A paired samples t-Test compared the mean therapist response across early and late sessions of each of the six therapy groups and found no significant effect of session order.

APPENDIX XI

Signed Declaration

I, Keith Beach, hereby declare that this thesis has been composed by me and that the work is my own.

Signed. Date 22 March 2000